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IMPACT OF THE ADMINISTRATION'S BUDGET CUTS ON THE NATION'S PUBLIC HOSPITALS

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT

OF THE

COMMITTEE ON WAYS AND MEANS

HOUSE OF REPRESENTATIVES

NINETY-SEVENTH CONGRESS

SECOND SESSION

DENVER, COLORADO, JANUARY 12, 1982

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CONTENTS

	Page
Press releases of December 28, 1981, and January 8, 1982, announcing hearing	1

WITNESSES

Andrew, Sister Mary. (*See*, St. Joseph Hospital.)	
Boston, Mass., city of, Department of Health and Hospitals, David L. Rosenbloom	33
City of Memphis Hospital, Memphis, Tenn., William Jackson	189
Colorado Department of Health, Frank A. Traylor, M.D	23
Cook County Hospital, Chicago, Ill., Elliot Roberts	59
Dallek, Geraldine, National Health Law Program, Inc., Los Angeles, Calif	64
Denver, City and County of, J. L. Kurowski, M.D., and David Howe	8
Drozd, Paul, Los Angeles County-University of Southern California Medical Center, Los Angeles, Calif	41
Howe, David, City and County of Denver	8
Hubbard Hospital, Meharry Medical College, Nashville, Tenn., Andre L. Lee, DPA	192
Jackson, William, City of Memphis Hospital, Memphis, Tenn	189
Kleyn, Hans, on behalf of Sister Mary Andrew, St. Joseph Hospital, Denver, Colo	105
Kurowski, J. L., M.D., City and County of Denver	8
Lee, Andre L., DPA, Hubbard Hospital, Meharry Medical College, Nashville, Tenn	192
Los Angeles County-University of Southern California Medical Center, Los Angeles, Calif., Paul Drozd	41
National Health Law Program, Inc., Los Angeles, Calif., Geraldine Dallek	64
National Indian Health Board, Inc., Denver, Colo., Jake L. Whitecrow	88
Newman, Ray G., Parkland Memorial Hospital, Dallas, Tex	55
Parkland Memorial Hospital, Dallas, Tex., Ray G. Newman	55
Roberts, Elliot, Cook County Hospital, Chicago, Ill	59
Rosenbloom, David L., Department of Health and Hospitals, city of Boston, Mass	33
St. Joseph Hospital, Denver, Colo., Hans Kleyn on behalf of Sister Mary Andrew	105
Schoen, Cathy, Service Employees International Union, AFL–CIO	122
Schroeder, Hon. Patricia, a Representative in Congress from the State of Colorado	4
Service Employees International Union, AFL–CIO, Cathy Schoen	122
Traylor, Frank A., M.D., Colorado Department of Health	23
Whitecrow, Jake L., National Indian Health Board, Ind., Denver, Colo	88
Wirth, Hon. Timothy E., a Representative in Congress from the State of Colorado (statement presented by Betty Miller)	5

SUBMISSIONS FOR THE RECORD

Bellevue Hospital Center (New York, N.Y.), Madeline Bohman, statement	203
Colorado Association of Community Health Centers, Stanley J. Brasher, statement	209
Harris County Hospital District, Richard L. Durbin, statement	214
National Association of Health Services Executives, John Noble, statement	184
National Association of Public Hospitals, Larry S. Gage, letter and attachments	218
Valley Health Plan (Fort Lupton, Colo.), Stanley J. Brasher, statement	209

IMPACT OF THE ADMINISTRATION'S BUDGET CUTS ON THE NATION'S PUBLIC HOSPITALS

TUESDAY, JANUARY 12, 1982

House of Representatives,
Committee on Ways and Means,
Subcommittee on Oversight,
Denver, Colo.

The subcommittee met at 1:30 p.m., pursuant to notice, in Old Supreme Court Chambers, State Capitol Building, Denver, Colo., Hon. Charles B. Rangel (chairman of the subcommittee) presiding.

[Press releases announcing the hearing follow:]

[Press release No. 14, Monday, December 28, 1981]

Hon. Charles B. Rangel (D-N.Y.) Chairman, Subcommittee on Oversight, Committee on Ways and Means, U.S. House of Representatives, Announces a Field Hearing in Denver on January 12, 1982, on the Impact of the Administration's Budget Cuts in Health and Public Assistance Programs on the Nation's Public Hospitals

The Honorable Charles B. Rangel, Chairman of the Subcommittee on Oversight of the Committee on Ways and Means, announced today that the Subcommittee will conduct a hearing on January 12, 1982, in Denver, Colorado, on the impact of Federal program revisions and budget reductions in health and public assistance programs on the fiscal stability and capacity of the Nation's public hospitals to deliver needed health services to their communities.

Major program changes and reductions in Federal funds for various health and public assistance programs are beginning to have a significant and adverse impact on the capacity of the Nation's public hospitals to provide needed health care services to low-income people who have neither public nor private insurance and cannot afford to pay for this health care. These developments have further exacerbated the financial strains already experienced by a great many public hospitals because of general economic conditions, the rising costs of health care and severe local fiscal problems. As a result of recent Federal budget cuts, for example, many States are cutting back their Medicaid programs which account for anywhere between 35 to 80 percent of a public hospital's patient revenues. "Clearly, the Nation's public hospitals are facing the most serious impending financial crisis in their history," said Chairman Rangel. He further stated, "Because of government cutbacks in support for health services to the poor, many public hospitals which today represent the only realistic source of care for the poor may be forced to sharply reduce service or even close their doors. Such an event could have catastrophic consequences for the health and well-being of an enormous number of needy people as well as for our hospital system." Mr. Rangel singled out the States of Illinois, California, Massachusetts and Colorado as among those which have begun to report fiscal problems in the continuing management and performance of their public health facilities.

The precise time and location of the hearing will be announced in a subsequent press release. The Subcommittee will be seeking testimony and data on the scope and ramifications of this crisis from state and local government officials, hospital administrators and other knowledgeable individuals.

[Press release No. 15, Friday, January 8, 1982]

HON. CHARLES B. RANGEL (D-N.Y.) CHAIRMAN, SUBCOMMITTEE ON OVERSIGHT, COMMITTEE ON WAYS AND MEANS, U.S. HOUSE OF REPRESENTATIVES, ANNOUNCES FURTHER DETAILS ON THE FIELD HEARING TO BE HELD IN DENVER, COLO., ON JANUARY 12, 1982, ON THE IMPACT OF THE ADMINISTRATION'S BUDGET CUTS ON THE NATION'S PUBLIC HOSPITALS

The Honorable Charles B. Rangel, Chairman of the Subcommittee on Oversight of the Committee on Ways and Means, today announced further details on the field hearing in Denver, Colorado, on Tuesday, January 12, 1981 (as previously announced in press release #14), to assess the impact of federal budget reductions in health and public assistance programs on the fiscal stability and capability of the Nation's public hospitals to deliver needed health services to their communities.

The Subcommittee has invited State and local officials, administrators of public hospitals, and representatives of low income persons who depend on public hospitals for health care to testify. The invited witnesses will appear individually and in panels as listed below:

PUBLIC HEARING—BEGINNING AT 1:30 P.M.—OLD SUPREME COURT CHAMBERS, STATE CAPITOL BUILDING, DENVER

J. L. Kurowski, M.D., Manager of Health and Hospitals, City of Denver. Frank Trayler, M.D., Executive Director, Colorado State Health Department. Rubin Valdez, Executive Director, Colorado Department of Social Services.

PANEL OF MEMBERS OF THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS

David Rosenbloom, Commissioner, Department of Health and Hospitals, City of Boston. Madeline Bohman, Executive Director, Bellevue Hospital Center, New York City. Paul Drozd, Executive Director, Los Angeles County/USC Medical Center, Los Angeles. Ray Newman, Chief Operating Officer, Parklawn Memorial Hospital, Dallas. Elliot Roberts, Executive Director, Cook County Hospital, Chicago. Richard Durbin, Chief Administrator, Harris County Hospital, Houston.

PANEL ON HUMAN IMPACT

Geraldine Dallek, Health Policy Analyst, National Health Law Program, Los Angeles. Richard Buckanaga, Executive Director, Denver Indian Health Board. Sister Mary Andrews, President, St. Joseph Hospital, Denver. Cathy Schoen, Special Assistant to the President, Service Employees International Union, Washington, D.C.

PANEL OF MEMBERS OF THE HEALTH BRAIN TRUST OF THE CONGRESSIONAL BLACK CAUCUS

John Noble, President Emeritus, National Association of Health Services Executives, St. Louis. William Jackson, President, City of Memphis Hospital. Andre Lee, Executive Director, Hubbard Hospital, Nashville. Charles Mitchell, Vice President, Colorado Board of Health.

Chairman RANGEL. The Subcommittee on Oversight of the House Ways and Means Committee will come to order.

We will have Patricia Schroeder, our dear friend and colleague and one of the most outstanding leaders in Congress to share the hearing with us and, of course, Congressman Don Bailey, from Pennsylvania, who serves on the committee.

Our hearing today is part of a series of hearings that we have been conducting in order to ascertain the impact, both fiscal and human, of the recent Federal budget cuts.

We have taken testimony all over the country in order to test just how much strain local governments in the network of public and private institutions have been under as they attempt to deliver services to the poor and the disadvantaged.

While this pressure has increased, we have not specifically reached out in order to check the impact on public hospitals and we know that traditionally and historically the public hospital has been the only door to health care that the poor have had in this country.

We are concerned—as responsibility has shifted from the Federal Government to the States and local governments who, themselves, have had limited resources—about the future of public hospitals. Will they be able to continue the role to take care of those who cannot take care of themselves? And while there was a general consensus there are people in the United States who are going to need it, is the Federal Government fulfilling its responsibilities to the counties and the cities as they attempt to hold on to their public hospitals?

No matter to what major city you go in this magnificent land, be it the city of Chicago or Boston, you find the public hospital is being threatened. The fact remains that the crisis that now confronts our public hospitals does not lend itself to a simple solution and it is clear that we in Congress must better understand the problem and come forth with solutions and ideas. We must make certain that this last hope for the disadvantaged in this country to be able to receive some type of health care is not taken away as we talk about saving ourselves in the free world and getting America back to work.

I want to commend the organizers of the conference that's being held this week in Denver by the National Association of Public Hospitals to come up with some of the answers that are so sorely needed. It is encouraging that in time of crisis, instead of just running for cover and bemoaning what has happened, that this group of dedicated people have come together to see whether or not they can come up with solutions to the problem.

It is for that reason that the committee thought that it was most important that we come to Denver to get the benefit not only of the expert witnesses that will be testifying from the city of Denver, but also from members of the National Association of Public Hospitals to let them know that when we go back into session that we hope to be wrestling with these problems and coming up with the answers that will give some hope to some of the people throughout these States.

[The prepared opening statement of the chairman follows:]

Opening Statement of Charles B. Rangel

Our hearing today is part of a series of hearings we have been conducting to assess the fiscal and human impact of the recent federal budget cuts. We have taken extensive testimony about the effects these cuts are having on the capacity of both local governments and the network of public and private institutions to deliver needed services, particularly to the poor and disadvantaged.

However, one aspect of the overall problem that has not received the attention it deserves is the increased pressure these budget reductions have put on the public hospitals in their efforts to deliver needed health care services to all those who cannot pay for their care. And this increased pressure comes at a time when public hospitals are particularly hard-pressed. State and local government fiscal assistance is a vanishing resource; the costs associated with the delivery of hospital services have been rising at an alarming rate; and the recent growth in the population unable to pay for care have all combined to accentuate the fiscal crisis public hospitals have been facing for several years.

No one wants to see the public hospitals go under. On the contrary, I believe there is a consensus on the need to enhance their capacity to deliver services. Historically, they have been a vital component of our hospital system, assuring access to care for all those residents of the communities in which they are located who might otherwise have been neglected. The disappearance of public hospitals from the landscape of health care would be a major catastrophe.

Yet the fact remains that the fiscal crisis now confronting our public hospitals does not lend itself to a simple solution. It is intimately related to a variety of other issues now clamoring for our attention and must be addressed in that context. What we need to have in the Congress, therefore, is a clearer perception of the nature and scope of the crisis, more specific information on what is really happening to these hospitals and their patients, and the advice of those public officials and hospital administrators who are directly involved in the continuing effort to preserve and improve this invaluable health resource.

Fortunately, we are meeting at a time when much of that needed expertise is readily available to us. The National Association of Public Hospitals is holding its first annual conference in Denver this week and several distinguished members of the Association have consented to appear before us today.

I might say that I have long been an advocate of the need for such an Association, and I am gratified that it has finally come into being and is taking steps to bring the many problems facing public hospitals into sharp focus. I want to commend the organizers of the conference and to assure the members of the Association that they will have in this Committee a receptive forum for the results of their deliberations.

Chairman **RANGEL**. I now would like to recognize Congresswoman Schroeder.

STATEMENT OF HON. PATRICIA SCHROEDER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. **SCHROEDER**. Thank you very much, Congressman Rangel.

I don't sit on Congressman Rangel's subcommittee so I am very honored to sit in today, and I especially want to thank him for coming to Denver. Usually the way we strong-arm your colleagues into coming to the mountains is by being on the committee and throwing tantrums, threatening them if they don't come. But we are really enthused you did come. I think it shows everyone how very serious we are about this problem in this very difficult area.

In Colorado we are pleased to have you here because we do have some specific local health care problems that we would like to be able to focus on and I think what so many people have overlooked is that Colorado's share of Federal health care funds are going to be cut about 26 percent in 1982, and we all know that our population is certainly not dropping in that order.

We also know that in Denver the department of health and hospitals was forced to cut its budget by another $10 million in 1981. We know that health care costs are rising faster than the rate of inflation and the average cost of hospital care is rising. It is going up nationally at the rate of 16 percent, whereas in Denver, unfortunately, it is going up 19 percent, so we are really feeling the pinch even more.

None of us really have a crystal ball at this table so we can tell exactly what's going to happen in the future with new budget cuts and how it is going to affect the future health care systems. We all know what the questions are. I guess the questions are how we, as a nation, can stem the rate of inflation, control the Federal budget, stop deficit spending, and still provide basic Government services and still provide adequate health care for America's citizens.

So we know what the problems are and I think we are very, very honored to have you here to look for the solutions and look for them out in the hinterlands rather than in the marble buildings with green felt tables back in Washington. So, welcome, we are glad to have you here and thank you very, very much for letting me sit in.

Chairman **Rangel**. Congressman Bailey.

Mr. **Bailey**. I have no statement, Mr. Chairman. I am just very happy to be here. Particularly I want to thank Ms. Schroeder. I had an opportunity to serve with her on the Armed Services Committee and have a great respect for her ability.

Thank you.

Chairman **Rangel**. Yes, I would agree with you that her strength is much stronger than the tantrum. [Laughter.]

We have the pleasure to have Dr. Kurowski, manager of health and hospitals, city of Denver, to testify.

Before you start, Doctor, I understand that Congressman Wirth cannot be with us but Ms. Betty Miller of his staff has his prepared statement.

Will you give your statement before the doctor and we will have the full statement placed in the record. We know how much the Congressman wanted to be with us and share his concerns with the committee.

STATEMENT OF HON. TIMOTHY E. WIRTH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO, AS PRESENTED BY BETTY MILLER

Ms. **Miller**. Thank you very much, Mr. Chairman, Representative Schroeder, and Representative Bailey. It also is a pleasure for me to welcome you to Colorado. We are very pleased at the opportunity.

Congressman Wirth had hoped to be here today but in light of the recent A.T. & T/Department of Justice settlement, I am sure you understand that he had some rather important activities going on in Washington today and did ask me to deliver this statement on his behalf. I appreciate the opportunity.

We once again would like to commend you for holding this hearing on the critical issue of the impact of budget cuts on our Nation's health care system and most particularly on public hospitals.

Some very tough issues are facing our Nation in the area of health care. But before I go into these, I think it is important to note some characteristics of our health care system today and to look at some of the trends that will force us to make some difficult decisions in the years ahead.

We have one of the best health care systems in the world and this has made the United States one of the world's healthiest countries. Improvement in our national health has not happened overnight nor has it happened by accident. During the 1950's and the early 1960's, we made little progress in improving our citizens' health. Infant mortality remained high. Progress in combating heart disease was very slow with the result that middle-aged men particularly were experiencing higher and higher death rates.

However, in the 1960's, substantial improvements began to be made and this progress continues.

Life expectancy of the newborn has risen to a record 73.3 years, an increase of 2.7 years since 1970. Fewer people under age 49 die of cancer because of the tremendous progress we are making in this field. Infant mortality rates have reached a new low, 13 deaths per 1,000 births, a 4.7-percent drop since 1965.

We have been able to make these significant improvements because as a nation we decided to make a commitment to developing a quality health care system which was affordable and accessible to all. This commitment has been fulfilled to a great extent because of the development of systems such as Denver health and hospitals.

The innovative approach embodied in D.H. & H. has improved access by developing an integrated health system, including eight sattelite primary care centers located throughout the Denver area. It has kept costs down by emphasizing the preventive care and education programs which have helped keep people out of hospitals unless necessary and by providing coordination with the other components of Denver's health care system.

As additional testimony before you today will indicate, this innovative structure has been instrumental in earning D.H. & H. a reputation as one of the best urban health care systems in the Nation. It has brought care to people in their own communities and helped erase the disparity in health care between low-income Americans and the rest of the population.

While our national commitment to health care has resulted in more and more people gaining access to quality care, it has also been very expensive. Americans spent over $255 billion on health care last year, an average of $943 per person. This amounts to about 10 percent of our GNP, and is the highest proportion in our Nation's history. In 1970, the country spent only 7.5 percent of its GNP on health care, a figure which was thought high at that time. Over 40 percent of these funds or $85.3 billion went to hospital care, the cost of which has been rising faster than inflation in the past several years. These statistics are startling and are enough to make the chronically ill and their families live in constant fear. Hospital and general health care costs can be expected to skyrocket. At the same time, the number of people who will need care can be expected to soar in this century and into the next.

Health care problems facing us today will be severely exacerbated by demographic changes taking place in our society. The elderly population rose from 9.7 percent in 1970, to 11.1 percent in 1980, and it is projected that by the year 2030, persons over 65 will comprise an unprecedented 20.4 percent of our population. This will have tremendous ramifications for our health care system. In 1965, 23.8 percent of the Nation's personal health care expenditures were for care of the elderly. By 1978, this had increased to 29.4 percent and will undoubtedly grow at a faster rate in the next 50 years.

The end result of rapid inflation and increased demand will be health care that millions of Americans may not be able to find or to afford. Already more than 20 million Americans may be without adequate health coverage. For them, a serious accident or illness poses a financial catastrophe.

What we should be doing now is searching for ways to respond to these developments while maintaining our commitment to quality and accessible care. But instead, we are seeing drastic budget cuts which respond solely to pressures to reduce spending without giving little thought to our Nation's health care needs, now or 50 years from now. I strongly believe that we must reduce the Federal deficit of more than $100 billion in 1982, and I have worked hard to do this. However, this must be done in an equitable way that maintains our commitment to our elderly and the disadvantaged in our society and prepares to meet our future needs.

In the past year, we have seen proposals succeed which will decrease the Federal support for medicaid by 3 percent in 1982, 4 percent in 1983, and 4.5 percent in 1984, and we have seen proposals which will increase the flexibility in guidelines in the medicaid program which will mean a significant reduction in services in many parts of the country.

The effect of these and other cuts is already being felt in communities around the country. Here in Denver, services have already been reduced, in large part due to less Federal funding. Denver Health and Hospital has had to make several reductions in the services it provides to the citizens of Denver, including the elimination of over 300 positions, the elimination or severe cutback in programs which provide preventive health services, such as the preschool diagnostic programs, and significantly reduced mental health, pediatric and geriatric services.

Indications are that there will be even more drastic Federal budget cuts proposed in these areas in upcoming months. This, coupled with the reductions already made, will result in the elderly and the poor being denied access to quality, accessible and affordable health care. The Federal Government is reneging on the national commitment we made in the midsixties and the poor and the elderly will be the ones who have to pay the price.

Rather than slashing away at programs which fulfill national priorities and which meet the needs of Americans, we should be looking at other more equitable ways to reduce the deficit, including real tax reform and cutting the waste we all know exists in the defense budget.

At the same time, Congress has been wallowing in talk and not action on health care reform for many years. We must get serious about redesigning our system to meet the changing needs of our society. More money on expensive hospitals is not always the answer nor is high technology the solution to every medical problem.

Part of the solution to skyrocketing medical costs and increased difficulty of access to quality care can be seen in programs which are preventive in nature and which save money in the long run. D.H. & H. has developed some such models. The child diagnostic program and maternal and child health efforts such as nutrition and monitoring programs are examples which are effective both in cost and in quality care. They present unnecessary and expensive institutionalization while providing personalized community based care.

We must not ignore the national commitment we have made. We must continue to provide the necessary funding to insure that a quality, affordable and accessible health care system is maintained. We cannot turn our backs on the poor, the elderly and the disabled in this country and deny them the health care that is the right of every citizen.

At the same time, we must muster the tremendous political will and vision to make the structural changes necessary to provide the kind of nationally accessible health care we need.

Thank you very much for the opportunity.

Chairman **Rangel**. Thank you, Mrs. Miller. The Congressman will be reminded of the professional way that you delivered his testimony.

Ms. **Miller**. Thank you very much.

Chairman **Rangel**. Dr. Kurowski, the good work that you have been doing in the city of Denver has been expressed in Washington by Congresswoman Schroeder, as well as the testimony just given by Mrs. Miller for Congressman Wirth, so we are glad that you were able to make yourself available for these hearings.

STATEMENT OF J. L. KUROWSKI, M.D., MANAGER, DEPARTMENT OF HEALTH AND HOSPITALS, CITY AND COUNTY OF DENVER, ACCOMPANIED BY DAVID HOWE, DEPUTY MANAGER OF OPERATIONS AND FINANCE

Dr. **Kurowski**. Thank you very much, Congressman Rangel, and Congresswoman Schroeder and Congressman Bailey, thank you for being here today.

I am Dr. Jim Kurowski, manager for the department of health and hospitals, city and county of Denver. On behalf of Mayor William H. McNichols, Jr., I welcome you to Denver and wish to tell you he shares your concern for the impact of Federal policies on the people of Denver as well as other cities across the Nation.

As the manager for a health and hospital system that has a large public general hospital, I wish to recognize you, Congressman Rangel, for your continued concern for access to health services and recognition of the role of public general hospitals. In your letter you asked for testimony on the impact of Federal reductions on Denver General Hospital. In doing that I will briefly review the following:

One, geopolitical position of the city and county of Denver;

Two, a description of the Denver health and hospitals system;

Three, the Denver health and hospitals revenues by source from 1976 to 1980;

Four, reductions in health services forced in 1981;

Five, Federal/State actions in process; and

Six, current dilemmas facing Denver City and Denver County and the department of health and hospitals.

GEOPOLITICAL POSITION—CITY AND COUNTY OF DENVER

The city and county of Denver, with a resident population of 500,000 (the exact count is in dispute and will be settled in court) is the core city of the Denver metropolitan area which has a total population of 1.6 million. The daytime population soars to about 800,000. Like most core cities, Denver is facing a multitude of problems, though these may not be of the magnitude of those facing the eastern cities. Denver's geopolitical boundaries have been frozen by actions of the State. It appears the State action was a reaction to the Federal initiatives particularly in school desegregation. Thus, a Federal action intended to bring people together, had the unintended consequence of separating us in new ways. Thus, with limited growth and a limited tax base, the city and county finds itself increasingly at the mercy of the Federal and State policies. Nowhere is this more true than in the area of health services delivery. In the 1970's, Federal policy shifted incrementally from a focus on increasing access, improving quality, and removing financial barriers to a focus on restraining the increases in cost of service. In 1981, it appears the direction of Federal policy is reversing with the impending implementation of a procompetition, deregulatory approach. The effect will be to shift the focus of financial responsibility from the Federal Government to the State and local government, the employer, the insurer, the providers, the family, and the individual. The impact of this health policy change on Denver General Hospital is best viewed in the context of Denver's health and hospitals system.

HEALTH AND HOSPITALS SYSTEM

The mission of the department of health and hospitals is threefold: (1) to provide health services to the medically indigent; (2) to provide emergency health care to anyone in the city and county of Denver, regardless of residence; (3) to provide general public health services for the protection of the public, including disease control, regulation of insititutions, vital statistics, et cetera. The Denver system has been evaluated by national experts and has been repeatedly honored for its innovative design. The system is unique; it combines a public general hospital; emergency medical services (including ambulance and paramedic services); a decentralized community health center program; a component of the community mental health center program and; a home care system under dual public/private governance. In addition, the Denver system includes the public health protective services of disease control, coroner's office, and environmental health. This complex system has evolved in response to community needs and to gaps in the community health services. The policy directions of the Federal Government and State government, through program initiatives, have been followed by the city and by the agency. An extensive development of ambulatory services has enabled Denver to substantially reduce the infant mortality rate, in addition to reducing total costs by minimizing our patient's hospital utilization. Thus, the overall goal is to assist people to live increasingly independent and to safeguard the public's health through the provision of effective and efficient health services.

The system functions both as an agency of Denver City and County government in concert with other local government services and as a provider of health services in concert with other local health services providers. A classic example of coordination of essential governmental services is the city and county's emergency response system through the 911 line. In order to be effective, this service has been established as a closely integrated system between the department of public safety, that is, fire and police, and the emergency medical services of health and hospitals. Thus local government can maximize its citizen protection by having a health services response for the victims of crimes, accidents, and fires. As a provider of health services, the Denver health and hospitals system complements the work of the voluntary nonprofit, the university, and the private hospitals by serving primarily the medically indigent, and those who are a danger to the public health by virtue of a medical problem such as tuberculosis. As a result of Denver health and hospitals attending to these community needs, the community is better protected and the community's health professionals and hospitals are enabled to serve the majority of the broader community's health care needs. This relieves those institutions of significant costs that, in the absence of the Denver health and hospital system, would be passed on to them, to their patients, and to the health insurance system. In addition, you will see far fewer people on the streets of the Denver metropolitan area who suffer from far advanced disease conditions than is evident in most cities. The system has been responsive and effective. This is not to say that Denver health and hospitals cannot be improved, and we are constantly searching for ways to increase both effectiveness and efficiency. The health and hospitals system has developed under the leadership of Mayor McNichols, the board of health and hospitals, and many leaders in the community and in the health and hospitals agency. In the course of this development, many services have been initiated under the direction of and funding by Federal and State government. However, you will see there has been a significant change in the source of funds.

HEALTH AND HOSPITAL REVENUES BY SOURCE

In demonstrating the local government commitment, I will review the revenue source data for fiscal year 1976 and 1980. There is a consistent trend occurring over these years, shifting the financial burden from the Federal and State governments to the city and county. The expenditure of these resources demonstrates the mayor's recognition of the importance of health services as a component of effective local government.

[A table follows:]

CHART I.—DEPARTMENT OF HEALTH AND HOSPITALS, REVENUE SOURCES FOR FINANCING PERSONAL HEALTH SERVICES (EXCLUDES PUBLIC HEALTH)

[Dollar amounts in millions]

Source	1976	1980	Percent change
Total	$44.6	$66.9	50.0
Federal	9.2	11.1	20.7
State	(8.6) 12.1	(10.7) 15.3	24.6
City	7.4	22.1	198.6
Collections	15.9	21.4	34.6

Dr. KUROWSKI. Chart I displays the revenue sources for the financing of personal health services. This excludes the funding for the traditional public health services such as vital statistics, disease control, et cetera. From 1976 to 1980, there was an increase in the total revenues of 50 percent. This represents a 12-percent average increase per year and if adjusted for health care inflation at an average of 15 percent would represent a decrease in real dollars. During that time there have also been significant shifts in type of services provided. An increasing proportion of services were protective of both the individual and the community, such as the alcoholism program which was developed in response to Federal and State direction. Federal grant revenues increased by 20.7 percent. The State grant and contract revenues increased by 24.6 percent. Noteworthy is the initiation of the State's medically indigent program. This program had the most significant influence on the agency's registration and billing policies over the past 4 years. Increased attention has been placed on registration, billing, and collection procedures since the inception of this program. The program, however, operates with a "capped" State fund, and the increases in the funding have not kept pace with either the service demands or inflation. The most notable statistic is the increase in the city's contribution from $7.4 million to $22.1 million, an increase of 198.6 percent. This incredible rate of increase has been brought to the attention of the State government annually but has generated only limited response.

[A table follows:]

CHART II.—DEPARTMENT OF HEALTH AND HOSPITALS, COLLECTION SOURCES FOR FINANCING PERSONAL HEALTH SERVICES (EXCLUDES PUBLIC HEALTH)

[Dollar amounts in millions]

Source	1976	1980	Percent of change
Total	$15.9	$21.4	34.6
Medicaid	6.7	8.2	22.4
Medicare	5.1	6.9	35.3
Blue Cross	1.1	1.3	18.2
Other	2.4	3.9	62.5
Patient pay	.6	1.1	83.3

Dr. KUROWSKI. With the increased attention on the business dimensions of patient care, there has been an overall increase in collections of 34.6 percent of the years 1976 to 1980. Chart II represents a more detailed breakdown of collections by source. There has been a substantial percentage increase in patient pay, but the amount collected represents a small amount of the total revenues. This reflects the financial ability of our patient population.

REDUCTIONS IN HEALTH SERVICES IN 1981

You must also be aware that the Denver charter wisely prohibits deficit spending. This has forced the mayor and the city to give attention to this growing problem. When I was appointed manager of health and hospitals on January 1, 1981, an adviser to the mayor was simultaneously appointed who would work with the city's office of budget and management and the management of health and hospitals to address this fiscal crisis. Given the direction of Federal policy, the focus of the financing for health services was clearly shifting to State government. As a former director of the State office of planning and budgeting, the independent adviser was considered to be in a position of credibility with the State government. The mayor's adviser conducted a study of mandated services, costs and revenues, and medical priorities for services with the agency management and the office of budget and management. Through the study, a $10 million reduction from the projected 1982 budget of $92 million was found to be unavoidable and the areas for service reduction were established. Much to my own disappointment, ambulatory care services felt the brunt of the impact of the reductions. This occurred because these services are less well reimbursed and because the services are of a less immediately life-threatening nature. It may be argued that some specialized outreach services should have been maintained. However, because specialized outreach services were not mandated and are less well reimbursed than the treatment services, reducing treatment services would have only led to greater revenue loss and therefore forced reductions in even more services. In addition, outreach services most often increase utilization of treatment services, which would have been reduced further and could not have withstood additional demand and maintain quality of service.

There is another dimension of the problem that must be considered, that is, the standards for the quality of care. If services become compromised to the extent that there are reasonable questions of the system's capacity to provide quality services, services must be eliminated rather than continued at a substandard level, for, if we provide care below community standards the risks and costs or professional liability for the city and county would be considerable.

As a result of the implementation of the study recommendations, significant programmatic units and services have been eliminated and the operations have been restructured to maintain health services in an even more integrated fashion so that highest priority treatment services, whether preventive or followup, could be handled in the context of the acute services. The delivery system has been adapted to: One, triage patients and serve those most seriously ill; two, take every opportunity within resources for providing followup or preventive services; and three, find every opportunity for reimbursement. This has placed substantial pressure on the professionals in our system to sort out the patients by priority and on the administrators to more aggressively enforce registration, billing, and collection procedures. The component of the registration process of determining the ability to pay has been improved. Charges have been reviewed to improve alinement with costs. The timing of the billing cycle has been reduced. Great attention has been given to integrating the business dimension of the patient care relationship, yet conducting ourselves in a way that is consistent with our commitment to the dignity of our patients.

The type of health services reduced or eliminated included general medical, specialty, dental, mental health, and social support services for adults and children. Fewer general medical services are available including internal medicine, pediatric and OB-GYN services for patients with serious conditions such as hypertension, coronary artery disease, arthritis, cancer, family planning, et cetera. Specialty backup has been reduced. The loss of the social support and outreach services has resulted in less staff available for assisting patients in sorting out the financial, psychological, emotional, legal, and social conditions which complicate their disease process and thereby affect their health. More responsibility will fall to the patient for his own care.

In the area of medical specialty care, two decentralized eye clinics were closed and the medical staffing for the central clinic was reduced 50 percent. As a result, only people with the more severe eye conditions will be served. The eye services total visits have been decreased in number by 50 percent. Less staff time will be available for followup on patients, many of whom have serious conditions such as glaucoma, cataracts, strabismus, and again more responsibility will fall on the patient for his own care.

The services which had the largest reductions were dental services. The dental services are organized as follows: Denver General Hospital Ambulatory Center has a dental/oral surgery clinic that serves as an integral part of the emergency medical services for such conditions as fractured jaws and traumatic injuries to the teeth. This is a 7 day a week, 24 hour a day service and it must have immediate on-call response. A staffing pattern is needed that will provide that coverage. In addition, the dental/oral surgery services must provide followup on emergency patients and respond to less severe acute conditions to the extent resources are available. Prior to the reductions, there were decentralized ambulatory dental clinics in six other facilities. The largest were in the two health centers, one on the eastside and one on the westside. The center clinics were reduced to minimal staffing to provide again for acute walk-in service. Preventive services are provided if staff is available or it is mandated by grant conditions. Services were eliminated entirely at the other four facilities.

We are experimenting with leasing these facilities to private dentists to maintain geographic access. One clinic has been opened by a dentist who was a former employee. It appears there has been some shift in the population he served in this facility. As a private provider he is providing services for more acute illness and fewer indigent patients. The services are carried out under the community health centers program. Negotiations for the reductions and reprograming of these services were carried out with the regional office of HHS by the directors of the program.

The program reductions which have elicited most reaction have been the substance abuse treatment service and the mental health services. In the past, the city and county has financed significant components of these services beyond State funding. Unfortunately, as a result of the findings of the study on mandated services, cost revenues, and priorities for care, reductions in these services were also unavoidable.

In the area of substance treatment services, negotiation for contracts were planned to be carried out with the State health department. The Legal Aid Society filed a lawsuit against the city and county and the agency, and as a result, a district court judge granted a temporary restraining order. The restraining order did not modify significantly the basic plan that was initiated. It did however, place the negotiations into court proceedings. Subsequently, the court conducted followup proceedings with the result that the city and county's basic plan has been substantially upheld. The issues that were debated appear to be: One, the temporary restraining order forced us to provide transportation for approximately 1 month from the one facility that was closed, to the second facility that was continued; two, the court forced wheelchair access under section 504 of the Rehabilitation Act of 1973, therefore we had to find a different facility to rent; three, the staffing ratios of patients to providers was disputed extensively. The State regulatory expert on substance abuse took substantive issue with the staffing patterns in the basic plan. The program reduction was targeted at serving the highest need patients and maintaining a 1:30 staffing ratio. However, the State expert took exception to the physician and nurse being counted in the ratio as counselors. As a result of court direction, the staffing patterns were modified to accommodate this minor change. Incidentally, the 1:30 ratio is the State standard, while the Federal standard allows a 1:50 ratio.

This program is funded largely through Federal to State pass through. It is my understanding this case is not closed. If the case is continued, it is most certain that the judge will need to examine the statewide needs for STS services for public protection and individual health needs. From that perspective, it appears the health and hospitals STS program serves the lower economic class, more difficult patients/clients. There is a second clinic in the city financed by the State and operated by the university hospital. It serves a higher economic class community. In addition, there are other federally funded State developed programs such as the cocaine abuse programs in Aspen. The court will inevitably move into priorities for community needs and be forced to examine the extent to which the State funding is following those needs across the State. The court has temporarily accepted the city and county's basic plan. Reduced services are in place under contract through the division of alcoholic and drug abuse of the State health departments. Further reductions in STS may be avoided by an increase in charges and hopefully an increase in revenues will result. Even in the program operated by health and hospitals, the STS patients appear to be in a somewhat better position financially than patients using other services in health and hospitals.

A revised design for the mental health services in the city and county was put into place at the direction of the division of mental health of the State department of institutions. Parenthetically, the reduction or closure of State mental hospitals and the deinstitutionalization of mental health patients has resulted in the city becoming a settling out point for many of the chronically mentally ill. Unfortunately, out of earlier Federal design for the community mental health center programs, the city had been fragmented into four catchment areas and this fragmentation has been continued by the division of mental health. The situation of fragmented catchment areas has markedly complicated the operational setting of patient care priorities for services to the chronically mentally ill. Historically the division of mental health has accepted the department of health and hospitals and the city and county government as only one of several private contractors for the provision of these services within the city/county boundaries. Out of the negotiations with the State division of mental health, a modified plan for services was developed and it appears the leadership of the division of mental health now recognizes the vital role of the health and hospitals system but not of local city and county government services. The State division of mental health has accepted the primary authority and responsibility for design of mental health services. Legal Aid and the Colorado lawyers committee have also filed actions for maintenance of the mental health services. The temporary restraining order for these services was denied. This action has subsequently been filed against the city and the State.

In total, it was estimated that the community would lose 250,000 of its more than 600,000 ambulatory service visits. Because of the skilled leadership and commitment of many staff in our agency, the total reduction of visits will be less than the 250,000 projected. In particular, I want to mention Dr. John Sbarbaro, Mr. Richard Poole, and Mr. Dave Howe, the deputy managers of the agency. Each of these men were in their positions when I assumed office, and forging these decisions and actions was truly completed with them. Preliminary data indicate the reduction will be in the range of 200,000. No doubt the burden of the loss of these services will ultimately be felt in the future because individual attention to health services has definitely been limited by the availability of resources. The full extent of the impact will not be known for some time.

FEDERAL/STATE PROCESS IN ACTION

One, the office of health care services of the State health department has informed us that the children and youth program funding will be reduced by a quarter of a million dollars for this fiscal year. Funds for these services were used entirely in the decentralized community health centers. The program directors are adjusting the priorities for services in this area.

Two, regarding the city's community health center grants, although we have not been officially notified of the specific amount of funding for this program, a reduction and a shift of program administration from the Federal regional office to the State health department in 1983 is anticipated. Reduction or loss of these financial resources for this program will result in substantial further dismantling of the system. This could eliminate the neighborhood based ambulatory services which would result in a significant redistribution of services and will lead to less effective more costly services. Higher total costs to the community should be expected as burdens are shifted to other hospitals, providers or to other agencies of local government.

Three, the more stringent Federal eligibility criteria for medicaid has caused a reduction of approximately 10 percent of the eligible population in the city and county. The number of people in need of medical services who will not have third party coverage from this source will consequently increase. This will shift an additional burden to the State medically indigent program. There have been recent discussions at the State department of social services regarding expanding benefits into the medically needy category of medicaid. This is a recent development and its feasibility is unclear at present. The funding for long-term care in nursing homes under medicaid has also been recently modified. The criteria for medical necessity for care will be scrutinized by more rigid criteria by the professional services review organization. It is likely to reduce significantly the number of patients in nursing homes for whom financing is available. We have not fully evaluated the impact of this action, but it is likely that many patients will become more seriously ill, be hospitalized, and be unable to return to a place in the community. The balance of services in the community is extremely important.

Four, Southeast Asian refugees have migrated into Colorado and their placement has thus far been carried out through nonprofit voluntary agencies such as Catholic Charities. The agency was initially told there would be $500,000 available for health services to these refugees. This funding is in limbo, while many services have already been provided. These refugees have significant medical problems which can be a significant danger to the local public health. The experience with one disease, tuberculosis, in this population is that 41 percent are infected and 1 percent have active disease and Denver can document a 25-percent increase in active TB cases in 1981, directly attributable to these refugees. In addition, their needs for personal health services are quite unique. During the inital settlement, these populations were distributed around the State; however recently, the community has begun to regroup into the core city, leaving the city with a specific burden.

CURRENT DILEMMAS

The current situation indicates that all sources of revenue are vulnerable and there is no indication that many of our current or many of our new patients will have a source of third party revenues. Consequently, there is no one competing for our patients. Even at current medicaid reimbursement rates, the community physicians and hospital institutions are very reluctant to accept these patients. It should be understood that health care providers are also under pressure for fiscal constraint and each recognizes the policy directions of reducing costs and charges. As this pressure continues, these providers are likely to deny services to these patients even in some emergency situation. Public general hospitals such as Denver General Hospital will be looked to as a provider of last resort. One can only predict an increase in the demand for services by more acutely ill patients presenting themselves to Denver General Hospital. This is already being felt. Thus, Denver City and Denver County and the department of health and hospitals are caught between the mandate for service and the mandate for fiscal responsibility. Denver City and Denver County government does not have the tax base to maintain this rate of increase in unreimbursed health care services.

As the Federal Government is using block grants to reduce and shift responsibility for the financing of health services to the State government, it is clear the State will have the lead responsibility for determining the services for the entire State, including the city and county of Denver. The impending future of increasing demand, decreasing resources, and potential liability from malpractice leaves the city and county of Denver and its health agency in a very tenuous situation.

It should be clear, that the decisions being made are, in fact, rationing health services and the pattern of financing these services will have significant influence on public protection, public health, and personal health. In closing, I will tell you of a trend that has recently come to my attention. When we are serving people, particularly at night, it sometimes is necessary to provide a lobby pass for patients to allow them to remain in our lobby as a place of shelter after they have been seen for their medical care. This is occurring with increased frequency. My office is currently working on guidelines for staff to determine those for whom we can provide this brief shelter. The department of social services, the police department, and our department are working under the mayoral direction to identify needs to which the voluntary community might respond. Hopefully this planning will be successful. While I am sure that all of us hope that the President's program will work, and that we will all be independent and self-supporting, it is unrealistic and unjustified to expect that people can tolerate loss of their basic survival needs such as employment, food, shelter, and health services and not take actions to provide for themselves even though the action may violate their own basic beliefs as well as those that hold a civilized society together. I would remind you that this is occurring in Denver, Colo., which currently has an overall unemployment rate of 3 to 4 percent. How much more serious might this become if unemployment continues to rise?

I thank the members of this committee for the opportunity to testify as to the events in this community. I hope the members of the committee will find a way to modify Federal policy direction, or at a minimum, slow its pace allowing the States, local government, and voluntary communities sufficient time to respond.

Chairman RANGEL. Thank you.

Mr. Bailey.

Mr. BAILEY. Thank you, Mr. Chairman.

Dr. Kurowski, I would like to ask you just a couple very simple questions. How are you structured, your operating authority, how is your hospital set up? Is it a corporate structure?

Dr. KUROWSKI. We are an agency of local government. We are a city charter agency similar to the department of safety—fire and police.

Mr. BAILEY. A municipal corporation?

Dr. KUROWSKI. It is not a corporation. It is an agency of local government, per se.

Mr. BAILEY. What is the tax base like in the State of Colorado? Do you rely essentially on property taxes, fees, licensures? Do you have a State income tax, a flat tax, a graduating income tax?

Dr. KUROWSKI. My expertise is not State tax structure.

Mr. BAILEY. What tax do you pay?

Dr. KUROWSKI. Income and sales taxes are the primary taxes; property taxes——

Mr. BAILEY. Sales and property taxes are your primary taxes?

Dr. KUROWSKI. No; income and sales.

Mr. BAILEY. Income. Is it a flat income tax, do you know, or do you pay more as you——

Dr. KUROWSKI. It is graduated and follows the Federal income tax.

Mr. **Bailey**. Did you receive a reimbursement from the Federal Government as part of medicare costs that you were able to put into a capital formation fund or sinking fund or whatever you want to call it?

Dr. **Kurowski**. If you wouldn't mind, Mr. Bailey, I would ask that Mr. Howe, who is the deputy manager for operations and finance for the agency, join me. He can address those questions more specifically.

If I could go back to——

Chairman **Rangel**. Without objection.

Dr. **Kurowski**. If I could go back to the question you asked on our corporate structure, there is a separate enterprise fund for the personal health services and a fund for the public health services. The latter is part of the city and county general fund.

Mr. **Bailey**. Capital costs?

Dr. **Kurowski**. That was not in response to the question on capital costs but to your question on corporate structure. The enterprise fund is used for the personal health services delivery systems as contrasted with the public health services. These services are billed to individuals, or third parties, as is found to be appropriate.

The city and county picks up the funding that is unfulfilled in the enterprise fund at year end.

Mr. **Bailey**. Mr. Howe, are you familiar with the question?

Mr. **Howe**. Yes, sir, I am. The answer to the question on capital costs is "No." There was no reimbursement for replacement in the capital formation fund because there is no such fund.

Mr. **Bailey**. There would not be anyone who was legally constituted the way you are?

Mr. **Howe**. That is correct.

Chairman **Rangel**. Mr. Howe, would you fully identify yourself for the record?

Mr. **Howe**. I am Dave Howe. I am the deputy manager of operations and finance, department of health and hospitals, city and county of Denver.

Mr. **Bailey**. So the point would be that in order for you to meet not only the immediate patient costs that you have, but in order for you to deal with any kind of continued future delivery of services and improved services, if the Federal Government doesn't help, you are just going to have to go to the pocket of the city or county or State, however you are constituted out here for any capital improvements.

You have done that in the past. However, the percentage of Federal help is now diminishing and dropping.

Mr. **Howe**. That is correct. By and large, all capital expenditures, both for large equipment items as well as for structural type capital improvements have been funded by the city and county of Denver out of a special fund which has been established for that purpose within the city and county of Denver funding.

Now, some of that money may well come from such things as general revenue sharing, which is Federal money, but I am not prepared to address that. I don't know the specifics of that.

Mr. **Bailey**. One last question: you mentioned various sources of revenue. We have heard a great deal about how the private sector is going to replace the income that you are going to lose from Government sources, that is from charities and from individual contributions and that kind of thing. I know people are going to try. I am sure you are going to make every effort you can to raise funds if you can. I don't know how you are set up out here, what you've got, but is there anyway at all from private sources you can replace some of that lost revenue?

Dr. KUROWSKI. First of all, generally there is a position within the philanthropic community that it cannot assume general operating costs of government.

Second, there is a generally held position that the department of health and hospitals is a public institution and private corporate leadership feels that we are supported through taxes and not through——

Mr. BAILEY. So you don't draw much charity?

Dr. KUROWSKI. No, sir.

The only way of drawing funds is by providing services for people who have a way of paying. We are trapped because most of our patients by definition do not who have the means of paying or a third-party payer.

Mr. BAILEY. I thank you very much.

Thank you, Mr. Chairman.

Chairman RANGEL. Congresswoman Schroeder.

Ms. SCHROEDER. Well, thank you, and I appreciate your testimony. I am delighted that you could present it so well.

I think, really, for the committee, what you are seeing here—and let's dramatize it—this poor gentleman has been one of the people that really the Federal Government has almost deputized to go out and deliver bad news because by cutting back so severely, you are the ones who really took an awful lot of that this year, and I think probably next are the most severe cutbacks in the city and county this year, and your patient load didn't drop.

If I can ask a question, as I listened to your testimony, I thought what you were telling Mr. Bailey was that one of the ways the care is really going to be affected by the budget cuts is you are forced more and more to deal with emergency, very serious cases and less and less with preventive. Is that a fair characterization as the squeeze comes?

Dr. KUROWSKI. Yes, I think that's a fair characterization.

Ms. SCHROEDER. Has anyone ever looked at—that seems to be tremendously shortsighted because while you might have went through a couple of years and then further down the line, aren't you going to have many, many more or much more serious problems occur because you had to lay low on the preventive? Has anyone ever looked at that?

Dr. KUROWSKI. I agree. There are many studies that have looked at the effectiveness of preventive services. The exact impact isn't necessarily linear, but that is structured by the reimbursement mechanisms—what services will be paid for and which ones which will not be paid for. If we provide those services that are preventive in nature for which we are unlikely to achieve reimbursement, we will end up having to reduce even more services. This will result in a further accelerated downward spiral. As you point out, the Federal policies are in many ways shortsighted, but for us there is not a real alternative pattern of reductions because this allows us to maintain more preventive services than we could if we saved preventive services and cut out, say, the hospital services.

Ms. **Schroeder**. One of the things that might be helpful, because some of my colleagues are asking me about it, is the uniqueness of the Denver General Hospital, which I think a lot of people don't understand, and that it does serve people who are not residents of the city and county.

Dr. **Kurowski**. That is correct. We serve anyone who presents themselves to our system. The program policy directions that have influenced us most as to who we serve has been the Colorado medically indigent program. This program has established admission criteria and the registration process. The medically indigent program provides an opportunity for some reimbursement on a billed basis for Colorado residents, whether or not they reside in the city and county of Denver.

However, in the past it has only reimbursed us 47 cents on the dollar for every dollar we bill. This percentage will improve somewhat this year after the reduction in services. In addition, the State joint budget committee did take an action to minimize the utilization of residents outside of the city and county of the health and hospital system. We have been working with the department of social services and University Hospital, to focus on serving only our own geopolitical entity.

Ms. **Schroeder**. But unlike a lot of other cities, we have no Federal public hospital in the city.

Dr. **Kurowski**. Correct.

Ms. **Schroeder**. Our University Hospital has not always been funded at its maximum. Really, the Denver General Hospital has really borne the brunt for an awful lot of people who live in the whole State.

Dr. **Kurowski**. Yes, and we are the provider of last resort for a large community. I'd add the political leadership views these services as somewhat of a thankless proposition. The more such funds have been provided, the more we subsidize other entities. Patients come from over the State, from over the country and sometimes from outside of the country, to use our services. This puts our elected officials in a very difficult situation. What are our commitments? Local governments have commitments in other areas for services that often are considered more basic local governmental responsibilities.

I would mention also that this has been—there have been tremendous changes in Denver government in this past year. User's fees have been developed for the public library system, the zoo, and the museums. It has been a very dramatic, dramatic change.

Ms. **Schroeder**. I think all the gentlemen at the table are politicians so they understand it is very gutsy of our city officials to be willing to increase some of the burden of carrying the hospital when really it is used by anyone in the State. The State and Federal Governments really haven't responded in the same way they have so they have been gutsy and they have stood up well.

Thank you very much.

Chairman **Rangel**. Thank you.

Doctor, you are a medical doctor, as well as administering this program?

Dr. **Kurowski**. Yes, sir. I am a physician and my specialty is public health and preventive medicine.

Chairman **Rangel**. So to determine where the cuts would be as the Congresswoman was stating and being shortsighted as to cut out the nutrition program, preventive services and the neighborhood clinics, it would be your political posture that you have to select those programs that are reimbursable, but certainly not your medical position that we are making the right decision?

Dr. **Kurowski**. Well, I think the point is a little more intricate, Congressman. We did not eliminate all preventive services; we maintained every facility in the community health center chain with reduced staff and in doing that, we will provide some preventive services with acute services. Some parts of the program that are solely preventive have been eliminated.

Chairman **Rangel**. Well, I assume, as a physician, that you would reach the conclusion that if certain preventive services were available and were not cut back, that in the long run it would prevent more serious diseases and perhaps more serious hospital care. Does it logically follow that what you do for prenatal, what you do for an infant, and what you do during the formative years would have some impact on the development of that person if the care is available?

Dr. **Kurowski**. Yes, it does, Congressman, but as I mentioned, it is not an exact linear relationship. We have some unique opportunities that may not be present in other public general hospitals. We have decentralized ambulatory clinics and we're able to maintain these. We reduced services in the hospital, but these were subspecialty services that were important but of lower priority.

Chairman **Rangel**. Well, we are not experts. We try to make decisions based on testimony that we receive and experiences that we have in our own districts. It is just that we don't hear too much from the American Medical Association in terms of providing funds for preventive care as much as we hear providing funds for reimbursement. In any event, the President has pointed out, as Congressman Bailey said, that we should lean more heavily on the private sector and while you are not receiving charitable contributions, you do have nonpublic hospitals in Denver, don't you?

Dr. **Kurowski**. Yes, we do, sir.

Chairman **Rangel**. How many?

Dr. **Kurowski**. Seventeen.

Chairman **Rangel**. It is hard for me to understand as a layman how these private hospitals can shift patients who don't have the ability to pay to the public hospital system. Do they deny care? Do they wait for the reimbursement period to expire? Do they have their own private ambulances that run from the private hospitals to the public? I mean do they check alien status?

Dr. **Kurowski**. Well, I can't speak entirely for the policies of other hospitals. But I can speak to certain situations. The department runs the emergency medical ambulance system for the city and county. We are, indeed, the receiver of the acute crisis patients and through a number of other hospitals in their designated categories for trauma care. We deliver patients to them and we have agreements with them where they must serve the patient, regardless of the patient's ability to pay under those circumstances.

Chairman RANGEL. That's when you get them first?

Dr. KUROWSKI. Yes, sir. So we do transfer patients in that way. The other hospitals are also facing a financial crunch but, yes, they do go through what is referred to as a wallet biopsy in nonemergency cases. [Laughter.]

I think that's consistent with the policy directions that say you must have fiscal responsibility. When you have left people uncovered for health insurance status, this is bound to happen. This is the woeful window that has been left in this Federal policy.

Chairman RANGEL. It is bound to happen if we are bound by the profit and loss statements.

Dr. KUROWSKI. The extent to which we are.

Chairman RANGEL. Well, you see, there is so much wide support for this administration's economic recovery package, and a large part of that support is based on the private sector's reaching out and filling the gap that's left by the Federal entrenchment, as well as the State. Any State tax program that was based on our tax program lost a lot of revenue, and I guess we have to find out just what private sector the President is talking about because most of the private sector that I see is running away from this alleged responsibility.

Dr. KUROWSKI. I think you are absolutely correct.

Chairman RANGEL. Tragically, some of the hospitals that are run by a religious institution sometimes they think their balance sheet comes out before the Bible in terms of what they are prepared to do. But I don't want you to get involved because I am flying out tomorrow. [Laughter.]

Dr. KUROWSKI. Thank you.

Chairman RANGEL. I want to thank you for what you are trying to do here. I don't know where we go. What you are saying is that because you are able to provide services for those people who don't have coverage, who don't have adequate coverage, then this serves as a magnet for people who know they will be turned away from other institutions of health. They come because they are sick and because they need health care and the more you try to do, the more is expected. You are going to have to rely on the good people of Denver to continuously pay more taxes in order for you to continue your work.

Dr. KUROWSKI. Well, I would say that the future is that the city and county of Denver cannot provide the financing for health services delivery. We are looking to the State to provide the leadership because funds are being administered through them. The State has a much larger tax base and serves a much broader community above and beyond the city and county.

If we are not recognized for what we are doing, I am very fearful as to our future. We have then the option to either become a private institution and forget the people we serve, or that we stay with our main mission of serving the poor and the needy, which I believe——

Chairman RANGEL. Well, I don't know what your experience has been but this committee, in going around the country, has not found governments and State legislative bodies prepared, especially in the election years, to increase taxes. So I wish you well.

Thank you.

Dr. **Kurowski**. Thank you.

Chairman **Rangel**. Dr. Frank Traylor, executive director of the Colorado State Health Department. Thank you so much for making yourself available to the committee.

STATEMENT OF FRANK A. TRAYLOR, M.D., EXECUTIVE DIRECTOR, COLORADO DEPARTMENT OF HEALTH

Dr. **Traylor**. Mr. Chairman, Congressman Bailey, Congresswoman Schroeder, I am Dr. Frank Traylor, executive director of the Colorado Department of Health, and acting executive director of the Colorado Department of Institutions.

The department of health is responsible for contracting for the care of citizens treated under programs such as handicapped children, migrant health, alcohol and drug abuse treatment programs. It is also responsible for the State laboratory and for the managing of the environmental programs delegated to it by the Federal Government.

The department of institutions is responsible directly or through contract for the care of the developmentally disabled, for the mentally ill, and for the care of juvenile offenders.

As the acting director of the department of institutions, I am responsible for the management of two public mental hospitals: Colorado State Hospital at Pueblo, with approximately 700 patients; and the Fort Logan Mental Health Center in Denver with approximately 250 patients.

The moneys that go to these hospitals is both State money, general fund, and medicaid which, of course, is a State/Federal match.

The Federal Government through its bloc grant system is providing money to the community mental health centers and because of the fact that a number of the categorical grants which are in existence and still running through this fiscal year are paying money to this program, the community mental health centers have not suffered a marked decrease in their funding.

However, when the categorical grants run out and the bloc grant is cut further during the next Federal fiscal year in October 1982, there will be a tremendous impact on community mental health centers. Community mental health centers are the alternative to what we used to have in the early sixties of large mental hospitals. Our State hospital had 7,000 or 8,000 people in it. We now have 700. These people are being taken care of by community mental health centers. Getting mental patients into the hospital, getting them out of the hospital, is a job of the community mental health centers.

I feel that within the next year there will be a tremendous adverse effect on this treatment system which will impact the whole system.

Now to prevention: During my 3 years as service as a chief health officer in Colorado, I have been impressed with the tremendous debt we owe public health. This is particularly true since I was a surgeon before I got my job.

During the last 50 years, a large, cumbersome, yet effective system for the prevention of disease has been created in this country. It is the effect which recent budget cuts will have on this system that I wish to discuss.

Although various programs of this system are not administered by public hospitals in Colorado, the integrity of these programs for preventing disease has a large impact on the population served by public hospitals and on the public hospitals, themselves.

Public health programs may have been damaged by their own success. The public has forgotten the times when smallpox, diptheria, polio and water-borne diseases were endemic in our country. Unfortunately, these public health programs are inherently socialistic. They involve telling citizens what to do, where to dump sewage, trash, noxious materials, and so on. When the Federal Government reduces its support for these necessary programs, I fear that conservative State legislatures and State governments will not assume the responsibility for this activity.

Some examples, primarily in prevention, the handicapped children's program: By early treatment of deformities often prevents larger costs later. For example, we have computed that the treatment of a dislocated hip in an infant very early in life has a cost/benefit ratio of 80 to 1, as compared to the surgery that is necessary when a child reaches a later age and starts to walk.

Handicapped children is only one part of the title V block grant. This grant has received an 18 percent reduction from the funding level of the previous year.

I would like to point the Colorado infant mortality rate between 1970 and 1979, the infant mortality rate, which means death in the first year of life, decreased by 47.5 percent from 20 to 10.5. The neonatal death rate, that is the death rate in the first 28 days of life, during the same period decreased by 57.6 percent from 15.1 in 1970, to 6.4 in 1979. I would like to refer you to the graph on the last page of the handout which shows you that Colorado started out at a rate above the national average in 1960, and has fallen to a rate below the national average in 1980.

Early prenatal care and effective treatment for the premature infants is responsible, in my opinion, for a large part of this improvement. Colorado had a unique combination of Federal, State, local and private programs to manage the premature infants. For example, Children's Hospital has been responsible for regionalization of this care. We have four neonatal intensive care units in Denver; two in public hospitals, one at the University Hospital and one at Denver General.

Through this network, however, children from Wyoming and western Nebraska are referred here because there are no facilities to take care of these children in Wyoming. I would like to point out that Wyoming's neonatal mortality rate for the last few years computed to be lower than that of Sweden's, a goal which I think everybody has been shooting for. This is the only State that has achieved this. We can all be proud of this achievement. I think Children's Hospital, and our network is partly responsible for this.

The number of children immunized against infectious diseases has dramatically increased since the passage of the School Entry Immunization Law, which became effective in 1979 and 1980. While nearly 98 percent of the school children are properly immunized, whereas only 75 percent of the 2-year-old population was properly immunized.

In 1976, there were 476 cases of measles reported in Colorado. In 1981, there were only 10 cases. The current immunization funding level has been reduced by 11 percent or a decrease of $32,000.

A word about our public health laboratory: Public health laboratories are not glamorous. It is rather dull work. The State doesn't like to support the public health laboratories. We have been supplementing our public health laboratory with funds from 314-D of the Public Health Act, which provided us $950,000 4 years ago. It was dropped to $850,000 the next year. Last year we were supposed to get $440,000, but we got a recision which we found out about half way through the year, so we had $110,000. This current year we are due to have approximately $400,000 that has been restored to us, nearer the previous level before the recision.

Nevertheless, this has a tremendous effect on the number of programs, particularly in venereal disease. This program, itself, has been cut 51.5 percent. This certainly will have an impact on a persistent, serious public health problem.

Finally, I would like to talk for a moment about genetic counseling. This State has received Federal funds in the past for a genetic program which includes counseling and testing. Under Federal funds we set up a laboratory which performs screening tests for six metabolic diseases: hypothyroidism, phenylketonuria, hemocystinuria, maple syrup urine disease, galactosemia, and sickle cell anemia.

When the Federal funds for this ran out, the State legislature established a program which allowed—which billed the mother of the patient so that the $5 for the test that is sent to the State to run the laboratory. Now, we do this for three States, Arizona, Wyoming, and for our State of Colorado.

Unfortunately, there was no money to take care of the genetic counseling, the genetic counseling of parents of children at risk of genetic defects. This also takes care of—this also has a laboratory component, too, which has no cash. So we would ask the legislature to take this over and I am pessimistic about the chances.

In conclusion, I would like to say that I feel that our preventive system does suffer the possibility of damage from funding cuts. Certainly not all of these funding cuts can be said to be as serious as others. There may be marginal costs which say you shouldn't take money out of one part of the system, but I would have to say that the things that we appreciate now are the good health and wellbeing that the American people deserve, that the American people have enjoyed, and that we have had in Colorado are in great measure the responsibility of the system which has been created in the last 30 or 40 years and which is now in jeopardy.

Thank you.

[The prepared statement follows:]

STATEMENT OF FRANK A. TRAYLOR, M.D., EXECUTIVE DIRECTOR, COLORADO DEPARTMENT OF HEALTH

PREVENTION AND DISEASE

Prevention is the cornerstone of Public Health. The old cliche, "an ounce of prevention is worth a pound of cure" is exactly on target.

There is a serious lack of emphasis on the detection and prevention of disease. Our society has developed an acute, curative, hospital-based system which consumes 67 percent of the total national health expenditure. For Colorado this equates to approximately $1,580,000,000.

When budget cuts are in the making, preventive services often are the first to go, even though they are the least expensive and the services which we know most about.

The Handicapped Children's Program by early treatment of deformities often prevents larger costs later. For example, treatment of a dislocated hip very early in life has a cost/benefit ratio of 80:1, as compared to surgery after a child reaches the age of one year.

Handicapped Children is only one part of the Title 5 block grant. The total grant has received an 18 percent reduction from the funding level for the previous year.

Colorado's Women, Infants and Children (WIC) supplemental food program, which has been in effect since 1974, has done an outstanding job in providing needed food supplements to malnourished children and pregnant women. There can be no cost/benefit analysis attached to the elimination of malnutrition which affects a child's intelligence or physical well-being. This worthwhile program should be preserved.

Between 1970 and 1979, Colorado's Infant Mortality Rate (death in the first year of life) decreased by 47.5 percent (20.0 in 1970 to 10.5 in 1979). The Neonatal Death Rate (death in the first 28 days of life) during this same period decreased by 57.6 percent (15.1 in 1970 to 6.4 in 1979). Early prenatal care and effective treatment for premature infants is responsible in large part for this improvement.

The number of children immunized against infectious diseases has dramatically increased since the passage of the Colorado School Entry Immunization Law, which became effective during the 1974-1975 school year. Today nearly 98 percent of the school age children are properly immunized, whereas only 75 percent of the two-year-old population is properly immunized.

In 1976 there were 476 cases of measles or rubeola. In 1981 there were only 10 cases; this is an 98 percent reduction in the rate of incidence. The current immunization funding level has been reduced by 11 percent, or a decrease of $32,000.

CLASSIC PUBLIC HEALTH ISSUES

Water Quality Control for municipal drinking water is in need of additional funding. This year a bill will be submitted to the Colorado Legislature which would provide grants to municipalities in order to provide the necessary equipment to remove waterborne microbiological and chemical contaminants such as Giardia and nitrates.

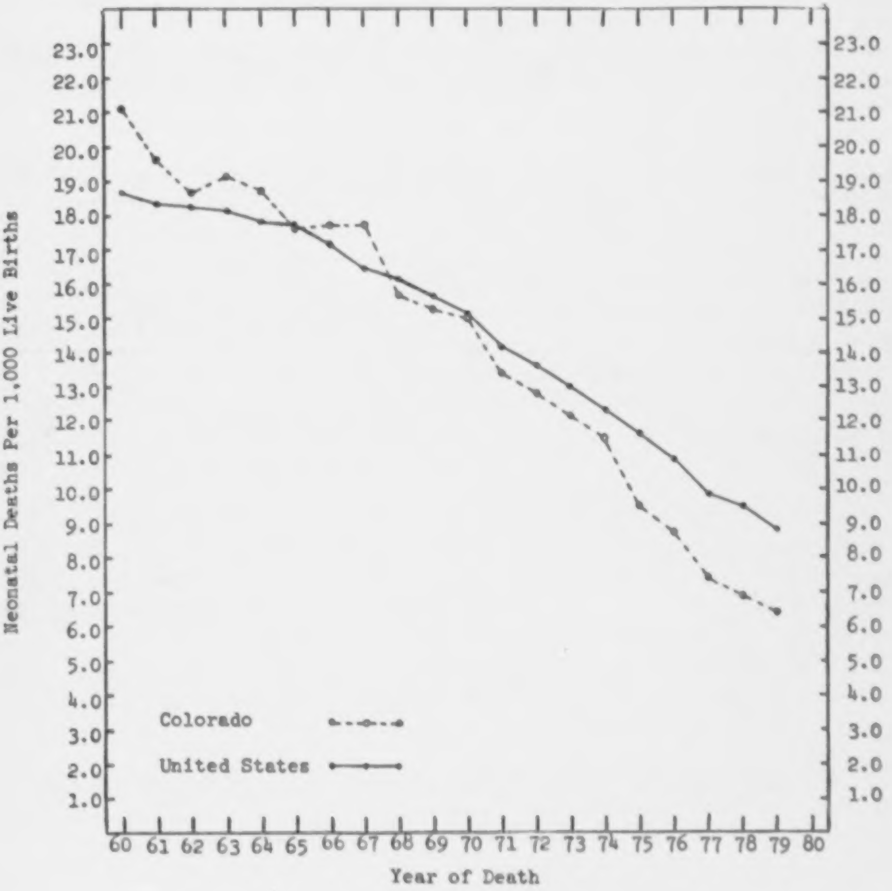
To date there has already been a 25 percent cut in 314-D funds, which in part provide for Consumer Protection Services. These services include the bacteriological analysis of milk, meat and other foods.

Today there are different infectious diseases to screen for. For example, penicillin-resistant gonorrhea, has caused additional research and materials for effective treatment; this all equates to additional dollars being spent. This year, however, the federal government cut 51.5 percent of the dollars from the Venereal Disease grant which was providing culture media to local clinics, family planning centers and others which screened for this disease.

NEW PUBLIC HEALTH ISSUES

Genetic Counseling, a service provided by University Hospital, has lost its grant and can no longer provide this service to those women who cannot bear full costs. Here is a clear example where technology is in place but the financing to maintain it is lacking. A previous federally funded program provided the following six tests for all newborn infants; hypothyroidism, phenylketonuria, hemocystinuria, maple syrup urine disease, galactosemia and sickle cell anemia. Since this federal grant expired, these tests are provided for a fee to newborn infants in Colorado, Arizona and Wyoming. This is a service which the state has assumed.

COLORADO AND UNITED STATES NEONATAL DEATH RATES, Colorado Residents, 1960-1979



Chairman **Rangel**. Mrs. Schroeder.

Ms. **Schroeder**. Well, I want to thank Dr. Traylor, who has been a good friend for a long time and I am delighted with your testimony because I think you tell the Congress like it is.

You don't really see a light at the end of the tunnel yet; would that be fair to say?

Dr. **Traylor**. I would have to say that in my life of running two institutions, two branches of government, has been fairly close to a disaster in the last several months.

Ms. **Schroeder**. Dr. Traylor is also a medical doctor and I first met him when I came to Colorado and he was practicing medicine very actively.

As we talk about how all these things affect preventive care, how do we get the medical society to speak up more? We get all caught up in the reimbursement game, too, because that's why we are here. Where is the medical society talking about what will happen if so many preventive things go down the chute?

Dr. **Traylor**. I think that the pediatricians in particular are very actively involved as far as prevention is concerned and we do have a committee.

Chairman **Rangel**. That's about reimbursement.

Dr. **Traylor**. Sir?

Chairman **Rangel**. They are the ones that are being cut out of reimbursement. I don't mean I think that's the reason they are active.

Dr. **Traylor**. I am not certain as far as what the official stances of the medical society are, but we have had a lot of contact with pediatricians, in particularly those at the Jewish Hospital and medical school, and so on, interested in genetics and interested in what happens to children in preventive programs.

A lot of prevention is taken care of by private doctors advising an expectant mother, for example, to get a proper car seat for their infant, and by nurses in hospitals teaching them how to take care of babies.

Now, this very well could suffer at public hospitals. That is the treating part. The people are paid to take care of this because when your funds are cut in the public hospitals, you take care of the person that comes in with acute illness and you have to let the rest slide by the wayside.

Ms. **Schroeder**. Well, I guess some reasoning on this, you would really rather have, as acting director of institutions—I can't help but remember, I wish I could remember the study, but I remember sometime in the early seventies—I guess it was the early seventies—someone did an institutional survey of the young children who were in institutions in Colorado for having misbehaved, become juvenile delinquents, and found an incredible percentage, it seemed to me over 80 percent, were undiagnosed learning disability problems. They didn't have proper visual attention or hearing attention, so you kind of draw the conclusion that they then became a problem and the problem got bigger and bigger and bigger, and I think it focused on how preventive care helps even in the other areas of the department of institutions which costs us dearly and we are under such a crunch to find more beds, more spaces, and I guess that's why it worries me so much.

I thank you for your testimony and for being here.

Dr. **Traylor**. Thank you.

Chairman **Rangel**. Mr. Bailey.

Mr. **Bailey**. Thank you very much, Mr. Chairman.

Dr. Traylor, I was very pleased to hear that you have provided some help and services and cooperate so well with my own many relatives. I have many of them that live in Wyoming and it is good to hear that you have a cooperative effort going out here to serve a very sparsely populated section of the country.

One—favorite Washington term—bottomline question: What, if you took a comprehensive view at the kinds of cuts that you are experiencing and will experience, what can the State replace? You know, something you said caught my ear and something that Chairman Rangel has been trying to fathom and I have been following on it in all these hearings—how are we going to replace all these services? You seemed to reflect as an aside that the State legislature or State government could not come up with the replacements. It's not a leading question but, really, what can you replace?

Dr. **Traylor**. Well, first of all, I used to be in the legislature and my wife is now a member.

Mr. **Bailey**. You are a many-faceted expert.

Dr. **Traylor**. So I get a lot of legislative talk from my wife.

First of all, our cuts have amounted to about $5 million. We wanted to go back with a supplemental request of approximately $1 million.

Mr. **Bailey**. You've had a $5 million cut from the Federal Government?

Dr. **Traylor**. Right.

Mr. **Bailey**. All right, you wanted to go to?

Dr. **Traylor**. To the State legislature.

Mr. **Bailey**. The State legislature for 20 percent of that?

Dr. **Traylor**. For about 20 percent. Our request which is being presented to the committee this morning is for $578,000; our total supplementary or our total supplemental request, our Federal fund replacements. Now, a word about the taxes. You asked about that, State income tax; the State income tax has a ceiling of 8 percent. I can't tell you at what point that's reached, but it is not very high.

Mr. **Bailey**. In other words, you have an income limited to 8 percent that it comes from. Hypothetically speaking, do you mean if I had an income of a million-two after Federal taxes, is that 8 percent on a million-two?

Dr. **Traylor**. Right, 8 percent's the top limit. Another source is sales tax and I believe there is a 3-percent sales tax levied by the State and the local governments have gone up to approximately 3-percent. The 3-percent sales tax is a very large part of the revenue for our cities in Colorado. In other words, as you might imagine, the State levies the income tax. Property taxes are levied by local governments and, of course, Denver, as you see, is more or less boxed in as far as growing.

Mr. **Bailey**. Do you have severance taxes in Colorado?

Dr. **Traylor**. We do. The severance tax was created several years ago and it has been a constant source of debate as to whether it should be increased, or not. The mining industry, coal, molybdenum, and uranium in particular have been depressed. It is a matter of contention whether the tax should be increased. There are a lot of layoffs.

Mr. **Bailey**. I asked that question because in this recessionary economy you probably don't have much of a resource in your tax structure with the exception of making up that income tax, and it is not going to be very popular to do that.

Dr. **Traylor**. There was a 1-year tax cut which was passed by the legislature for this current State fiscal year, which starts in July and ends in June, and that will expire at the end of this year. So if it does and the business picks up because that's——

Mr. **Bailey**. What was that surcharge on?

Dr. **Traylor**. I can't tell you the size of the tax cut but it was a 1-year tax rebate, so to speak.

Mr. **Bailey**. Oh, I see. It was a rebate. If it expires, you have added revenues coming?

Dr. **Traylor**. Exactly.

Mr. **Bailey**. You don't know how much that is?

Dr. **Traylor**. I cannot tell you exactly how much it is, except for the fact that the State government and particularly the legislature, did not predict the size of the recession, which has affected the tax receipts and so the State, really, is pretty close to zero as far as its resources at the present time.

Colorado had been very fortunate because prosperity has blessed us, but it didn't bless us quite enough this current fiscal year.

Mr. **Bailey**. Well, I am going to stick my neck out and conjecture that you obviously don't have the resources in this State to make up for the income that you are going to be losing. I assume what you are saying and you are obviously a very well-informed person and you come across very well, and that is that politically you think there is not too far you can go for expectations to be raised about revenue sources that would come up with that 80 percent shortfall?

Dr. **Traylor**. That's correct.

Mr. **Bailey**. Is that it in a nutshell? In short, somebody is going to die—and I don't want to sound like a demagog—but just somebody, some child, somebody that doesn't have the ability to pay is simply going to have to suffer.

Dr. **Traylor**. I would really be surprised if the full amount of Federal fund cuts in the health area, the prevention area, were replaced by State revenues. Some may be.

Mr. **Bailey**. Mr. Chairman, I have to leave to catch an airplane. I would like to again thank you and Congresswoman Schroeder for being such gracious hosts and being so helpful.

I would just like to comment that I think we are starting to find that that copious welfare state that everyone was talking about has turned out to be a very thin-skinned skeleton. Maybe those bones are starting to be hit right now.

Chairman **Rangel**. Well, I appreciate your contributions, Mr. Bailey. You have been around the country with the committee and I guess the audience should know that this is not unusual testimony we've been receiving.

Mr. **Bailey**. This is a State that ironically enough, Mr. Chairman, as you know, is one of the States with, in relative terms, a perhaps better picture than many of the industrial, Midwestern industrial and Northeastern States where the impact has been absolutely brutal. Believe it or not, you are actually well-off in comparative ways, and I don't mean that to be smart.

Dr. Traylor. We are.

Chairman Rangel. Dr. Traylor, you've heard the city testify it would hope to get help from the State. You are pessimistic, living through a disaster period now, that there will be help from the State. What economic group do you think will be impacted by a failure of some level of government to come forward?

Dr. Traylor. What economic group would be—sir?

Chairman Rangel. Would be impacted by the failure of local, State, and Federal governments to fail to come forward.

Dr. Traylor. Well, there are two groups I think of that would be the most affected by this and one would be, as far as Denver General is concerned, certainly the poor people who live particularly in Denver, but also in the environs.

The second thing is the normal person that is hit by a car or has a heart attack on the street, and I don't think problems choose between the rich and poor when those things happen. So there would be a general impact as far as emergency care is concerned.

Chairman Rangel. But the Federal policy that we have, the more wealthy part of our Nation's population, would not be impacted as the poor would be?

Dr. Traylor. I think that the poor people certainly would feel the brunt of this in regards to Denver General in particular.

Chairman Rangel. This is especially true with preventive care which upper middle-income families have as part of the normal day-to-day routine and physician checkups, especially where they have family medical plans.

Dr. Traylor. Private physicians and so forth.

Chairman Rangel. Private physicians, private medical plans, private hospitals.

Dr. Traylor. That's true.

Chairman Rangel. So really, when we talk about the social program, safety net, you are saying that in the progressive city of Denver, you are beginning to see some holes in that network if the Federal Government holds onto its position or put it another way, if the President is able to come back and get another $12 billion cut from these programs. You see that hole widening, don't you?

Dr. Traylor. I think that there is no question that you cannot take care of everyone if you are reducing the budget. But I would like to say parenthetically, I am not a manager by trade and I have a hard enough time managing in good times but when the Congress passes a budget which acts for 6 weeks and then comes back and cuts the funds again and we are going to have another 3 or 4 months and another cut, it is really difficult because we don't know exactly—we don't have any idea how much money we are going to get for the next fiscal year in our State health department budget, which is about 54 percent Federal funds. We are very susceptible to cuts.

Chairman Rangel. My problem, Doctor, is that voices are heard loud and clear throughout the Nation's capital when the administration talks about returning $800 billion to corporate structure, to the upper-income groups—many of us, of course, vote against those types of bills—but it's hard to hear many people speaking out for the poor. I don't know how it works here in Denver, but the previous witness was indicating that the private hospitals are rather selective with the patients that they take; that he takes whatever comes into his hospital and that he doesn't know how long he's going to be able to do it. The poor are not going to go away, the sick are not going to go away. I think you are suggesting that unless we have preventive medicine for the poor, we may have more serious ailments and I just was wondering whether you could forecast where all this was going.

Dr. TRAYLOR. It is difficult to forecast. I would say that there are too many people for private hospitals to take care of, too many people who are poor. In other words, you might say, "Well, the private hospitals are not taking care of people," and I do know that they do to some extent. But if you were to close Denver General Hospital, the private hospitals in Denver could not take up the slack. Denver General Hospital has to operate. That's the first thing. Second, it depends on the size and the length of the shock that the preventive system will have to bear, and, you know, you can always take a little bit of the hay away from the horse and it looks like the horse is OK, but when you don't give him anything at all, the horse gets skinny and dies. So how many transistors can you pull out of a computer before it doesn't work?

I can see if this continues, we will really have a serious problem in the preventive programs, which we are really proud of and everybody in the whole country should be proud of, that will falter so much that the disease incidence will go up. People will be sick who would not have been sick otherwise. But when that point is, it is hard to say.

Chairman RANGEL. It's hard to count these people that are sometimes aged and no one is there to account for how they passed away. I assume in Denver, as in the rest of the major cities, there are a large number who are minority groups.

Dr. TRAYLOR. We have significant Hispanic and black population, particularly in Denver.

Chairman RANGEL. So we don't have anyone taking that into account, either, do we?

Dr. TRAYLOR. I don't know how to answer that.

Chairman RANGEL. I am just saying they are not going to go away and they don't get health care if they can't get it——

Dr. TRAYLOR. No, you're right. In fact, they——

Chairman RANGEL [continuing]. From the private hospitals.

Dr. TRAYLOR. They tend to come to Denver.

Chairman RANGEL. They can't get it from the physicians and they can't get it from the Congress, so it is a major problem and all I am saying, and I think Mr. Bailey has said it, is that while it is uncomfortable to talk about, somebody is going to have to start talking about what is happening to our poor.

Dr. TRAYLOR. I agree.

Chairman RANGEL. Thank you so much and we hope we can turn it around.

Dr. TRAYLOR. Thank you.

Chairman RANGEL. We will now have a panel of members of the National Association of Public Hospitals. Let me seriously thank all of you for taking the initiative in not only pulling together this association, but in having this conference later this week. I think it is abundantly clear that while the Congress doesn't have all the answers, that the constituency that you represent—the least powerful that you can possibly think of in the United States of America, and not only the old, not only the poor, but the sick and the helpless—deserve to be heard. So it seems to me that where it is easy for a lot of people to shift the focus and see how it works out, it gives me a great deal of comfort to see that you have come to try to assist the Congress and other levels of government in coming up with some moral solution rather than sticking us with the easy political solutions or decisions which, unfortunately, the poor are victims of. I know what you are up against. Our committee has studied each and every one of your hospitals and we know that it is even contagious; the more you do, the more pressures that are placed on your hospitals and we don't know the answers.

But I want you and those that I won't be able to speak with tomorrow to know that this subcommittee as well as the full committee will be watching very carefully as to what recommendations come out of your conference because we are looking badly for some type of direction that is meaningful.

Mr. Rosenbloom from Boston.

STATEMENT OF DAVID L. ROSENBLOOM, COMMISSIONER, DEPARTMENT OF HEALTH AND HOSPITALS, BOSTON, MASS.

Mr. ROSENBLOOM. Thank you very much, Mr. Chairman, members of the committee.

My name is David Rosenbloom. I am the commissioner of health and hospitals for the city of Boston, and I am pleased to be here today.

My colleagues and I want to leave you with two simple points: First, the Nation's public hospitals are a vital part of the health care system of the country, particularly for the poor. Current Federal policy poses serious threats to the continued quality and existence of these hospitals. Local governments cannot and will not absorb the shift of cost now being attempted by the Federal and State governments, through reductions in entitlement programs such as medicaid and through major increases in copayments in medicare.

When public general hospitals start to close as a result of these Federal policies, and they will, we believe the entire fabric of health care and medical education in this country will be torn.

Second, the cost of caring for the poor and the elderly may very well be more expensive than the country can afford. However, the inflation in medical costs in the last 15 years was not caused by the poor and the elderly and they should not be punished for it. If you want to control the increase in health care cost for the poor and the elderly, you must control the industry that is getting the money, not the poor. Shifting costs from the Federal Government to the State government and then to the local government is a deception and a fraud.

The Nation's public hospitals whose rate of inflation is substantially below that of the rest of the industry, are on the receiving end of that fraud. We are here to tell you today that we cannot survive these policies.

Just over 20 percent of the country's hospital beds are owned and operated by local government. However, before medicare and medicaid, many of these systems were perceived by the public to be separate and unequal care for the poor.

We have made major strides in different cities across the country since the advent of medicare and medicaid to build single-class, high-quality systems. In Boston, for example, we built a neighborhood health center system that now provides care to one third of the people who live in the city. The system, which did not exist 12 years ago, will do a million visits this year.

There are full-time doctors and nurses in these centers. We have seen through their efforts a reduction in the infant death rate by more than half in this city. Nine of these health centers receive Federal title 330 money. If the medically underserved area designation is redefined as has been proposed by the administration, every one of these centers will lose all of its Federal money. If that happens, I think more than half of them will go out of business.

Boston is only somewhat unique in the changes that it has made in the last years. Throughout the United States, urban public hospitals provide similar care. They are the hospitals for all, regardless of eligibility for Government programs. Bed for bed, large urban hospitals around the country provide more specific facilities and services than any other group of hospitals. These include 24-hour emergency services, the shock trauma units, the burn centers, the poison control centers, the drug abuse and alcoholism services, the medical and social health programs, and the high volume ambulatory care programs.

For example, the emergency departments of the large urban hospitals—and here I mean the public hospitals in the 100 largest cities of the country, have more than twice as many visits as large university hospitals and almost four times as much emergency care as the private hospitals in these same cities.

In the 100 largest cities, the public hospitals represent only 1.6 percent of all of the hospitals, but they provide one quarter of all of the outpatient care provided in major cities in the United States. For example, just one public hospital, the Grady Memorial Hospital in Atlanta, accounts for 53 percent of all of the hospital-based clinic visits in the State of Georgia, and 12 percent of all of the emergency care in the State of Georgia, one public hospital.

There are about 7,000 hospitals in the entire country but 90 big-city public hospitals train 20 percent of all of the medical, dental interns and residents for the United States. The big-city public hospitals of the United States, many of whom are represented at this table today, are training the next generation of physicians for all of the people in the country, rich and poor.

Unfortunately, public hospitals operate on the verge of a state of acute financial distress which threatens at any point to substantially reduce or abruptly terminate their ability to provide services to the poor and to their community as a whole. They are substantially more dependent on medicaid and other public funding sources than other hospitals and they serve disproportionately fewer paying patients than other hospitals. It is the public hospitals therefore that will bear the brunt of the cuts in AFDC and medicaid entitlements.

In Boston, for example, since October 1, the AFDC caseload has been cut by 10 percent yet unemployment in Boston has increased by 60 percent in the last 12 months. In the next 3 months 36,000 people in Massachusetts will lose AFDC benefits as a result of the cuts implemented by the Federal Government and by the State. Some of these people are going to get sick and when they do, they will come to us for care.

I believe, Mr. Chairman, that the principal villain for the public hospitals in the changes now being made in Federal policy will not be the nickle and diming us on our rates but, rather, the number of people who will lose entitlement for medicaid eligibility and end up at the public hospitals.

The financial problems of the public hospitals are compounded because of the extra costs associated with hospitals' efforts to meet the special needs of low-income people and they are further complemented because we can't turn to any other level of government effectively for relief. Even prior to the passage of the Omnibus Reconciliation Act of 1981, States around the country had begun to try to contain their medicaid expenditures.

For example, even before the act of 1981 was passed, 10 States had placed limits on the number of medicaid eligible hospital days, 14 States had begun eliminating Federal optional benefits but benefits which are provided in the public hospitals, and 14 States have begun reducing the number of people eligible for diminished medicaid benefits. Eligibility criteria have also been tightened in States around the country, such as eliminating the 18- to 21-year-olds from medicaid eligibility.

Local relief from this financial squeeze is even less likely than State or Federal assistance. In many localities, particularly Boston, tax-cutting referendums have substantially reduced the funds available for any local purpose. In Boston this year, the city operating budget for all services is reduced 20 percent from the level at which we operated last year because of tax-cutting referendums.

Yet the rest of the health care industry will be relatively unscathed because just about everybody but the public hospitals will escape at least this first round of cuts.

The only hospitals that cannot escape are those who are taking care of large numbers of the elderly and the poor. These are the inner-city public hospitals and the small rural public hospitals. The private and nonprofit hospitals will survive this by limiting the amount of free care that they give.

Let me pose, Mr. Chairman, several specific suggestions of what you and your colleagues might be able to do to help the Nation's public health hospitals help the people who need our services the most, the poor and the elderly.

First—and I know this may sound ridiculous—but revive again and pass a decent program of national health insurance that will cover the 10 percent of the people who are still without benefits.

This 10 percent of the American people is not a very large number but they represent between 25 and 85 percent of the people who use our public hospitals.

Second, make sure that the Omnibus Reconciliation Act of 1981, that requires special consideration for hospitals serving the poor, in fact, is enforced and given meaning.

Third, recognize our bad debt and free care problems and make these reimbursable expenses under medicare. This alone would solve a substantial part of the problem of caring for the poor at public and private hospitals and would not be all that expensive on a national basis.

Fourth, place wage and price controls on the entire health care industry. Current Federal policy is placing income control only on hospitals that serve large numbers of the poor and the elderly.

Fifth, prohibit further increases in medicare copayments, particularly for the poor. These copayments are not, in fact, collected from many of the poor elderly who use our public hospitals and they merely increase the bad debt of the local hospitals.

Sixth, prohibit cuts in the community health care program any further than they have now been made. Cutting this program is particularly stupid since visits to these centers are usually at one half or one third the cost of visits at big-city hospital emergency departments.

Finally, spend some serious money to develop less expensive alternatives that will deliver high quality medical care with substantially less reliance on hospitals, public or private. The big-city teaching hospitals and the academic medical centers of America may require fundamental changes for their long-term survival and for the health care provision that people who use them need.

But if these changes are to be made without hurting the poor and the elderly, we shall need the help of your committee and others.

Thank you very much.

[The prepared statement follows:]

STATEMENT OF DAVID L. ROSENBLOOM, COMMISSIONER OF THE BOSTON DEPARTMENT OF HEALTH AND HOSPITALS

Mr. Chairman, members of the House Oversight Subcommittee. My name is David Rosenbloom and I am the Commissioner of the Boston Department of Health and Hospitals. I am pleased to have the opportunity to participate in this discussion.

My colleagues and I want to make one single and clear point here today. The nation's public hospitals are a vital part of the health care system, particularly for the poor. Current federal policy poses serious threats to the continued quality and existence of these hospitals. Local governments cannot and will not absorb the shift of cost now being attempted by federal and state policy for the care of the poor and the elderly through restrictions in entitlement and benefits for Medicaid and dramatically increased co-payments in Medicare

When public general hospitals start to close as a result of these federal policies—and they will—we believe the entire fabric of health care and medical education in this country will be torn.

Second, the cost of caring for the poor and the elderly may very well be more expensive than the country can afford. However, the inflation in medical costs within the last 15 years was not caused by the poor and the elderly and they should not be punished for it. If you want to control the increase in health care cost for the poor, you must control the industry that gets the money, not the poor. Shifting cost from the federal government to the state government and then to the local government is a deception and fraud.

The nation's public hospitals whose rate of inflation is substantially below the industry average are on the receiving end of the fraud. We are here to tell you today that we can not survive such a policy.

Just over 20 percent of the country's hospital beds are owned and operated by local governments. Next to public schools, hospitals are the largest municipal enterprise—and they are the only such enterprise that operates side by side with a similar private enterprise. For most of this century, in most major cities, the municipal hospital has been the anchor of local health care delivery systems. Since the early days of this century, cities have assumed a leadership role ensuring access to quality health care services. The municipal hospitals took care of whomever came in and the care was free for all consumers. However, before Medicare and Medicaid, most of these systems were perceived to be separate and unequal care for the poor.

In Boston, there has been vast change in recent years, but our municipal programs continue to provide the most important health care resources for the city resident. Even though we operate less than 10 percent of the acute care beds in the city, we handle more that 15 percent of all hospitalizations for Boston residents. Ninety-six percent of our patients are city residents, whereas no other hospital draws more than 40 percent of its patients from the city. We provide virtually all of the emergency ambulance service and 25 percent of all the emergency room care in the city. We train doctors, nurses, technicians, and entry level health care personnel. This year, for example, we will train 250 residents and interns, in conjunction with Boston University; several hundred nurses, at all levels, through our own and university-affiliated programs; 100 or more technicians of every type; and, through our own allied health training programs, more than 400 entry level employees.

Boston is only somewhat unique. Throughout the United States urban public hospitals provide the health care safety net for the poor. They are the hospitals of last resort for all the poor, regardless of eligibility for government programs. Bed for bed, large, urban public hospitals provide more specific facilities and services than any other group of hospitals, such as 24-hour emergency services, shock-trauma units, burn centers, poison control, drug abuse and alcoholism services, medical-social health programs, and high-volume ambulatory care. Emergency departments of large urban public hospitals have more than twice as many visits as large university hospitals and almost four times as many "emergencies" as large, urban private hospitals.

In the 100 largest cities, public hospitals represent only 1.6 percent of all hospitals, but provide almost one-fourth of all out-patient clinic services. For example, just one public hospital—Grady Memorial in Atlanta—accounts for 53 percent of all clinic visits in the entire State of Georgia, and 12.5 percent of all emergency room visits.

In 1980, six hospitals alone, all members of the National Association of Public Hospitals (NAPH) provided more than 1½ million out-patient visits and 850,000 emergency room visits.

	1980 visits—	
	Outpatient	Emergency room
Parkland Memorial Hospital, Dallas	218,283	174,213
Grady Memorial Hospital, Atlanta	490,220	223,513
Truman Medical Center-consolidated, Kansas City	133,705	37,081
Cook County Hospital, Chicago	326,025	270,796
Boston City Hospital	165,918	54,089
Nassau County Medical Center, New York	180,918	93,535
Total (6 hospitals)	1,514,310	853,227

There are about 7,000 hospitals in the country. Yet fewer than 100 urban public hospitals train over 40 percent of all medical and dental interns and residents. The six NAPH member hospitals mentioned above trained a total of 2010 interns and residents among them in 1980 alone. The average urban teaching hospital has 116 full-time-equivalent residents and spends more than $1 million annually on their salaries.

Our public hospitals are obviously a critical element in the health care delivery and education systems. We are proud of their contribution. Yet, we are faced with extremely serious problems.

SPECIAL POPULATIONS SERVED

Public hospitals often treat sicker segments of the populations than other hospitals; those segments with higher infant mortality rates, less adequate prenatal care, and higher incidence of lead paint poisoning. Public hospitals serve those with multiple diagnoses, whose problems are complicated by having been denied access to preventive care earlier in life, who may be alcoholics or drug abusers, or who have "spent down" into a state of indigency in the course of an expensive spell of illness.

Public hospitals must often be more than just acute care facilities to many of their patients, who have little or no access to "mainstream medicine" for primary care. They must also often take on specific responsibilities for special patient populations, such as refugees.

Five hundred thousand Indochinese refugees have recently entered the United States. While only 6500 have been resettled in Boston, it has been the public hospital and health department which has assumed responsibility for coordinating their health care. We are the only provider willing to offer needed but non-reimbursable health care services.

Other services needed by the patients of urban public hospitals are vanishing because of cutbacks in federal programs including: WIC, School Lunch Program, Cash Assistance—AFDC, Job Opportunities through CETA, Social Services through Title XX, and Preventive Health Services.

FINANCIALLY DISTRESSED

Public hospitals operate on the verge of a state of acute financial distress, which threatens at any point to substantially reduce or abruptly terminate their ability to provide services to the poor and their communities. They are substantially more dependent on Medicaid and other public funding sources than other hospitals, as they serve disproportionately fewer paying patients than other hospitals.

It is the public hospitals, therefore, that will bear the brunt of cuts in AFDC and Medicaid entitlement. In Boston, for example, since October 1st, the AFDC caseload has been cut by almost 10 percent. It will be cut by 12½ percent by the end of February. Thirty-six thousand persons will lose AFDC benefits in Massachusetts. Nationally, almost 1.15 million women and children will be cut from the AFDC program. When these people get sick and some will, they will need care. Who will pay for it?

I believe the principal villain for the public hospitals will not be the nickel and diming reimbursement rates of Medicaid and Medicare but the number of people who will lose their Medicaid eligibility and end up at our public hospitals.

The financial problems of the public hospitals are compounded because of the extra costs associated with the hospitals' efforts to meet the special needs of low income persons. They are further compounded because they cannot turn to state or local governments for relief.

Even prior to passage of the Omnibus Reconciliation Act, states had begun to try to contain their Medicaid expenditures. Ten states had placed limits on the number of Medicaid covered hospital days. Fourteen states had begun eliminating federal optional benefits but benefits which our public hospitals have historically provided. Fourteen states began reducing the number of persons eligible for diminished Medicaid benefits. Eligibility criteria have been tightened and groups such as 18-21 year olds eliminated.

Local relief from this financial squeeze is even less likely than state or federal assistance.

In many localities, particularly Boston, tax cutting referenda have substantially reduced funds available for any local purpose. In Boston this year, the operating budget is 20 percent smaller than last year. Basic police, fire and health services are all being reduced. There is no capacity for the city to absorb a cost shift for caring for the poor being cut from federal programs.

HEALTH CARE INDUSTRY

Yet the rest of the health care industry will be relatively unscathed because everybody but the public hospitals can escape. The only hospitals that cannot escape will be those taking care of large numbers of poor and elderly. The innercity public hospitals.

The private and non-profit hospitals provide only a limited amount of free care. In a survey of Boston hospitals, we found that more than half now require deposits prior to admission for patients without third party coverage. Private and voluntary hospitals will insure their economic security by not accepting or dumping indigent patients on the public hospitals. It is not unheard of for private hospitals to pay an ambulance to transport indigent patients from their doors to the doors of a public hospital.

MEDICAID AND STATE PROPOSALS

Federal and state governments have been actively discussing the problem of spiraling health care costs. The focus, regrettably, is usually containment of federal or state expenditures, and not the overall organization and financing of health care services. The Omnibus Reconciliation Act, for example, squeezes public hospitals by increasing the near poor population which will rely on us but not be able to pay for care. Controlling Medicaid and Medicare expenditures, only shifts costs to state and local governments, it does not necessarily reform the system.

RECOMMENDATIONS

Mr. Chairman, I would like to close with several specific suggestions of how you and your colleagues can help the nation's public hospitals help the people who need us most—the poor and the elderly.

(1) Pass a decent program of National Health Insurance.

(2) Make sure the section of the Omnibus Reconciliation Act of 1981 that requires special consideration for hospitals serving the poor is enforced at the federal and state levels.

(3) Recognize our bad debt and free care problems by making these reimbursable under Medicare—This alone would solve a substantial part of the problem of caring for the poor at public and private hospitals and would not be all that expensive.

(4) Place wage and price controls on the entire health care industry. Current federal policy places income controls only on hospitals that serve the poor and the elderly.

(5) Prohibit further increases in Medicare co-payments—particularly for the poor.

(6) Prohibit cuts in the Community Health Center programs. Cutting this program which serves so many poor and elderly is particularly stupid and probably a costly mistake.

(7) Spend serious money to develop less expensive alternatives that will deliver high quality medical care with substantially less reliance on hospitals—public or private.

The big city teaching hospitals and the academic medical centers may require fundamental changes for long-term survival. If those changes are to be made without hurting the poor and elderly, we shall need your help.

Thank you.

Chairman **Rangel**. Thank you, Mr. Rosenbloom.

Normally we wait until the full panel finishes testifying before we ask questions, but you gave such a big order for this committee. These private and nonprofit hospitals—is there some type of agreement between the public hospitals that you don't identify those hospitals?

Mr. **Rosenbloom**. No, we have a policy in which we are quite prepared to identify them.

Chairman **Rangel**. The reason I ask is that it is just taken as a matter of fact that, "Oh, they will survive because they don't have any moral obligations to take sick people," but only you do. I hate to see you come down like that on religious and charitable hospital institutions. I am assuming that if you are sick, they are going to open up their doors and take the sick.

Mr. **Rosenbloom**. Mr. Roberts from Chicago may wish to comment on that.

Mr. **Roberts**. That's a heavy order.

Elliot Roberts, director of Cook County Hospital in Chicago, and that which happened to us in Cook County, beginning in July, for one reason or another fairly well made some national headlines and to answer your question specifically, Congressman, no, there is no moral obligation not to reveal. I think what has happened over the years is that there has been the expectation that this would, in fact, occur. As the responsible chief executive officer for my own institution, my comment to the administrators of those institutions is that if, in fact, it is going to occur, you make certain that the transfer is appropriate and to the degree that there is a need to transfer within the city of Chicago, developed through the Chicago Hospital Council is a standard criteria for transferring patients.

Chairman RANGEL. Need based on what?

Mr. ROBERTS. Well, it sets criteria wherein a transfer is made and the transferring hospital has an obligation to do certain things. No. 1 and critical to that is to be certain that the receiving hospital acknowledges that the transferring hospital wishes to make the transfer.

Chairman RANGEL. But it's not based on the inability to pay?

Mr. ROBERTS. No.

Chairman RANGEL. So we're saying that none of your hospitals have experiences where patients are transferred from private hospitals to your public sector hospitals because they couldn't pay? You're not saying that?

Mr. ROBERTS. Oh, no, no [witness expressed many no's], I missed your question and if you thought what I was saying was that doesn't happen, the answer is no.

Chairman RANGEL. No, I'm saying that this question, no matter what hearing we attend, is always missing, and all I am saying is that, if it's a question of survival of the fittest, you're out of business if you are going to just testify that only the public hospitals have a responsibility to the sick and the poor. Morally, then, we shouldn't be hearing anyone coming to ask us to change the laws to make it easy for them to accept some of this burden.

You speak, Mr. Rosenbloom, of the great job that the public hospitals are doing to train doctors for the rich and the poor. Now, if this is a fact, then why is it the poor can't find all these doctors in the communities in which they live?

Mr. ROSENBLOOM. Well, in many cities the doctors leave the community as soon as their training is finished and they establish their private practice in areas that are inaccessible to the poor.

The point about the moral responsibility of the public hospital is simply put. The public hospital is the only hospital that cannot escape its responsibility.

Chairman RANGEL. No, I'm talking about the doctors.

Mr. ROSENBLOOM. We train the doctors.

Chairman RANGEL. You make a big point—I know you do. I know who is training them.

Mr. ROSENBLOOM. The unfairness——

Chairman RANGEL. I know who on which bodies they receive their training.

Mr. ROSENBLOOM. That is correct.

Chairman RANGEL. And sometimes it looks like we provide a training center for the United Nations with some of the doctors we have in public hospitals in New York. But you're saying that it is a great thing. Yet, when you are in trouble, none of these trained doctors in the suburban areas come forward to your conference to talk about where they received their training. The American Medical Association doesn't come forward and say, "Listen, I got my training from them. Give them a hand."

Like the time you have to wait in one of their waiting rooms and people know it so they come directly to you.

It just seems to me—and I don't want to stop the testimony—that the poor will need more than just you people on the firing lines if we are going to win because we don't have the votes in the Congress unless people who have a moral responsibility to speak out ask for a turning around in policies which this administration has taken. So I don't mean to embarrass you; I agree with everything that you have said.

Doctors in training have these contracts with the hospitals. They get paid for providing the services and I thought, perhaps, they would pay us for becoming doctors and leaving. But it doesn't work that way. We pay them.

Since I hope to participate in your conference, I thought it might be easier for me if I let you know ahead of time that we are going to need some help. We're going to depend on you, not to carry the whole moral and political responsibility, but to assist us in getting some of your colleagues that are not public hospitals to come with us, whether they are in the American Hospital Association or the Council of Christians and Jews or whatever—people who have made some type of commitment to take care of the sick. I hope you can call them together because all of the activity of the National Public Hospitals Association alone is not going to make any difference in February when we vote on the budget.

I would like to congratulate you, Mr. Rosenbloom, that you are the first person that I have heard since Mr. Reagan has taken office that has even talked about national health insurance. It's like a breath of fresh air.

Mr. **Rosenbloom**. I almost left it out but I couldn't.

Chairman **Rangel**. I am glad to hear it. I am sorry for the interruption but—from Los Angeles, Paul Drozd, executive director of the medical center there.

STATEMENT OF PAUL DROZD, EXECUTIVE DIRECTOR, LOS ANGELES COUNTY-UNIVERSITY OF SOUTHERN CALIFORNIA MEDICAL CENTER, LOS ANGELES, CALIF.

Mr. **Drozd**. Mr. Chairman, members of the subcommitte, I am Paul Drozd, executive director, Los Angeles County/USC Medical Center. Thank you for this opportunity to testify on these important issues.

I will give you a little bit of the same and maybe I will try to anticipate some of your comments and questions as we go along.

You have received a written presentation from me giving a detailed overview of the Los Angeles County hospital system and the problems that have been created by recent Federal and resulting State actions.

I will not duplicate that testimony. However, I would like to give you a brief overview of our system, the problems we have and then again make some suggestions which will be contrary to the current political mode in this country.

California counties, pursuant to State law, must support all indigent or incapacitated county residents not supported by their families or by State institutions. This duty has been defined by courts as medical care assistance as well as financial relief. We meet our medical care assistance obligation primarily through our county-operated network of seven hospitals, three comprehensive health centers and 48 community health centers.

This system accommodated over 1 million inpatient days and 4 million outpatient visits last year. About one half of this population, by default, are defined as county obligation patients. The remaining 50 percent are reimbursed to the county, 33 percent by medicaid, 9 percent by medicare and the remainder through private insurance or self-pay. That's an important number, less than 8 percent of our patients are insurance patients and our cost-shifting opportunities are zilch.

The hospitals have a total bed capacity of 4,826. Six of these hospitals are general acute teaching hospitals affiliated with the University of California at Los Angeles, University of Southern California, and the Charles R. Drew postgraduate medical school. We estimate that $260 million of the cost of operating these hospitals will not be reimbursed through State or Federal Government or private third-party payers this year.

County costs for health care has risen disproportionately to the cost for other county-operated programs; 47.3 percent over the past 4 years, as compared to 16.6 percent for other county programs such as law enforcement and other programs. This disproportionate increase can be directly attributed to the following: County hospitals are the providers of last resort for indigent persons requiring emergency and hospital care. In our trickle-down industry, the buck stops here.

Locally, health care costs have increased 65.7 percent over the last 5 years, compared to an overall CPI index of 49.9 percent. Existing medicare and medicaid reimbursement limitations are deleterious to the public general hospital.

Los Angeles County has clearly reached its limit with regard to funding increases in health care costs and maintaining the existing level of service. We went into this fiscal year with a proposed budget recommendation of $983 million to finance last year's level of service. Because of State and Federal actions and the limited local tax base, the level of service could not be financed. We were curtailed by approximately $70 million in appropriations.

My own hospital was curtailed $21 million which required a $21 million reduction in programs. Overall there was a 10 percent reduction in hospital costs which resulted in the closure of beds, a reduction in outpatient programs, which resulted in the queuing up of patients, closing of outpatient pharmacies which in a teaching hospital—if you will excuse the expression—made our doctors gag; a closure of eight comprehensive health centers and a reduction in personal ambulatory care, 10-percent reduction in services at four of our comprehensive health centers and a 20-percent departmentwide cut in administration.

I recognize that there are no simple or quick solutions to the problems I have expressed here and in my correspondence to you. Certainly a cooperative effort involving each level of government will be required to effectively resolve the issues contributing to our plight and the plight of most public general hospitals.

Your subcommittee and Congress might, however, consider the following relief actions: One, closing the gap between legislative intent and regulatory reality. The section 223 limitation currently being contemplated and those in effect in 1982, bear no resemblance to the legislative intent of Congress's 1972 amendment.

California today proposes a 6-percent cap on Medi-Cal—medicaid—rate increases for all California hospitals. In spite of Congress's intent that the "States take into account the situations of hospitals that serve a disproportionate number of low-income patients with special needs." County hospitals clearly fit that description.

Second, establish county health services system which function as providers of last resort as a special category of the State and Federal law. Special treatments would be provided to these last-resort providers in matters related to administrative procedures, regulatory control, hospital aid, and medicare and medicaid reimbursement. Third, extend medicaid and medicare coverage to persons on the basis of medical and economic need and without regard to the legal status of the applicant's residence.

Many areas of the Nation are burdened with the unreimbursed cost of providing care to the undocumented Federal taxpayer. To date, a great deal of debate has taken place over what level of government should bear that cost and whether our county's estimate of $100-plus million for providing that care is accurate.

While this debate continues, our ability to achieve maintenance level funding for our seven hospitals diminishes as resources become increasingly limited. Some form of Federal participation in these costs is required if we are to maintain the public hospital system in our counties.

Fifth, facilitate the passage of legislation at the next Congress that would assist financially distressed hospitals and promote the development of experimental alternatives and reimbursement models.

Last, authorize and finance a facility survey of the Nation's public general hospitals to assess construction or renovation needs.

The Los Angeles County/USC Medical Center best represents Los Angeles County's needs in this area. The general hospital unit, which has over 1,300 operating beds, was opened in 1933. The facility was constructed pursuant to the standards and state of the art for providing hospital care in that era. Almost 50 years later, the facility is still in full service and in need of over $9 million in identified and cited accreditation and licensing physical plant corrections. Financing these corrections alone would strain limited resources and this does nothing to enhance patient comfort or improve the outdated system in patient care unit configuration or their juxtaposition to support services.

Thank you, and I would like to make one comment on getting our community hospital brethren involved in care for the indigent. Health care administrators over the last few years, last year or two, have introduced a whole new vocabulary. If we talk about marketplace, market share, strategic planning, corporate restructuring and all of this, of course, has done one thing. It has stimulated the flow of entrepreneural juices in this country. Now, that is not intended to be a pejorative statement. It is a statement of fact, something that has made this country great, something that does need to occur.

However, for the marketplace models to work, the shift in emphasis is going to need to move from the provider to the consumer. So long as the emphasis on marketplace is with the consumer, you are going to find the entrepreneurs on the leading edge, positioning themselves in place where the money is and avoiding the places where the money isn't.

Thank you.

Chairman **Rangel**. Well, that doesn't help much but I would like to get back to that.

[The overview referred to follows:]

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Los Angeles County - University of Southern California
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SOL BERNSTEIN, M.D.
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SCHOOL OF MEDICINE
SCHOOL OF DENTISTRY
SCHOOL OF PHARMACY

January 7, 1982

Honorable Committee Members
Subcommittee on Oversight and
Investigation of Committee on
Ways and Means
House of Representatives
Washington, D.C. 20515

Dear Committee Members:

SUBJECT: IMPACT OF FEDERAL REIMBURSEMENT SYSTEMS AND PUBLIC FISCAL POLICIES ON PUBLIC HOSPITAL FINANCING AND OPERATIONS.

Thank you for the opportunity to address your Committee on this critical subject on January 12, 1982. I trust the information I share with you then, and in this correspondence, will assist your efforts to support financially distressed hospitals and local governments burdened with the ever-increasing costs for providing health care services to indigent persons in public-general hospitals.

OVERVIEW

There are approximately 23 million residents in California. This population is shared by 58 counties in a distribution ranging from approximately four thousand (4,000) in Alpine to over seven million (7,000,000) in Los Angeles.

Counties are political subdivisions of the State of California and are required by State law to provide for the public health and safety of their entire population and to provide medical care services to their indigent population. California Welfare and Institutions Code Section 17000, et. seq., defines the responsibility of counties regarding the latter. Basically, counties must support all indigent or incapacitated county residents not supported by their families or by State institutions. This duty has been defined by the courts as financial relief and medical care assistance.

Counties are not required to establish county hospitals to fulfill their medical care assistance obligation. They need only insure that medical services are available to all indigent county residents. Most counties, however, have established hospitals as the primary means of meeting this obligation.

Los Angeles County meets its indigent medical care obligation, along with providing services to Medicare and Medicaid (Medi-Cal in California) beneficiaries, through its County-operated health network of 7 hospitals, 3 comprehensive health centers and 46 community health centers.

The 7 hospitals have a composite licensed bed capacity of 4,826 (Attachment I). Approximately 4,300 of these beds are functional (i.e., in use or available for use within 24 hours). We anticipate the use of more than 3,200 of the beds on a regular basis and, accordingly, we prepare our budget on that basis. The operating budgets for the hospitals total approximately $702 million for the current year. State (AB 8) assistance, revenue sharing funds, and County General Fund dollars will contribute toward the relief of approximately $240 million in unreimbursed costs incurred by the hospitals.

Six (6) of the hospitals are general acute or specialty care teaching hospitals affiliated with the University of Southern California, the University of California at Los Angeles, and the Charles R. Drew Post-Graduate Medical School.

The primary collective function of the 7 hospitals is to provide a full range of medical care to Los Angeles County residents, particularly to the indigent, the aged, the young and the handicapped. This effort has resulted in a system total of over one million inpatient days for Fiscal Year 1980-81. One-half of the patients treated at County facilities are covered under Medicaid (Medi-Cal). The remaining patients consist of 7% Medicare, 6% private pay, 6% covered by other programs and 31% indigent. Workload, revenue, and cost report summaries for our hospitals for Fiscal Year 1980-81 are provided in Attachments II and IIa.

Our 7 hospitals, together with the health centers operated by the County, accommodate more than 4 million outpatient visits per year. This network forms a coordinated and efficient public health care system.

In 1966, California had 64 county hospitals. By 1979, this number had been reduced to 38. Currently, 29 counties operate a total of 37 hospitals. The closure, sale, lease or transfer of 27 county hospitals over the last 15 years can largely be attributed to the increasing inability of county governments to bear the high costs associated with public-general hospitals. The crisis which counties in general, and Los Angeles in particular, are facing in health care financing can be summarized as follows:

1. Health care costs are being driven upwards by inflation.

    — Health care costs nationwide in the past five years have increased 59.3 percent compared to an increase in the General Consumer Price Index of 47.2 percent.

    — Locally, health care costs have increased 65.7 percent, compared to an overall CPI increase of 49.9 percent.

2. Other agency support (Federal/State/private) for Health Services is inadequate.

- Federal reimbursement limitations for Medicare will cause a loss of $5.6 million to Los Angeles County for treating Medicare and Medi-Cal patients, even after all exceptions have been taken.

- An additional $13.8 million loss is estimated with the implementation of the new State inpatient hospital reimbursement regulations. The State's ceiling on Medi-Cal outpatient rates will result in a loss to Los Angeles County of $26.6 million.

- $9.2 million of Medicare and Medi-Cal revenues will be lost due to more stringent share-of-cost and eligibility regulations.

- Ineligible undocumented aliens now account for 20% of hospital patients, compared to 16.5% three years ago. This represents a cost to the County in excess of $100 million.

- Medi-Cal audit exceptions over the next three years pose a $75 - $80 million unfunded liability.

3. Capitalization requirements for severly depreciated facilities exceed the ability to finance renovation or new construction projects. Many counties have closed their hospitals in lieu of financing renovation projects to meet code and licensure requirements.

With the passage of California's Proposition 13 in 1978, and with revenue reductions caused by increasingly restrictive third party reimbursement policies implemented to facilitate "cost containment", county health care delivery systems were rendered financially "at risk". Recognizing the plight of local government, the California Legislature passed a long-term (bail-out) financing proposal (Assembly Bill 8) in 1979 which included provisions for grant subvention of unreimbursed county health care costs. Generally, the measure provided for 50 percent (50%) reimbursement of these costs.

While this assistance is significant, it has not eliminated the financial crisis confronting county health care delivery systems. Assembly Bill 8 (AB 8, Chapter 282, Statutes of 1979) was designed to assist counties with their indigent care obligation. Counties also provide medical care to Medicare and Medi-Cal beneficiaries. In many countines, 30 to 50 percent of the county patient population are Medicare and Medi-Cal beneficiaries. Accordingly, counties are financially plagued by the increasingly restrictive reimbursement policies of these programs.

MEDICARE

In 1972, Congress amended the Medicare Act in a fashion allowing the Secretary of Health, Education and Welfare to impose certain cost reimbursement limitations on hospitals participating in the Medicare program. The purpose of such limitations was to encourage efficiencies by limiting reimbursement to those costs which would be incurred by prudent and cost-conscious management. Congress expected this limitation to apply to a relatively small number of hospitals, namely those with extraordinary expenses. (H.R. Report No. 92-231, 92nd Congress, Second Session).

The Secretary's initial regulation implementing these limitations was adopted in 1974, as Section 405.460 of Title 42, Code of Federal Regulations. It sought to disallow reimbursement of hospital "routine costs" which exceeded a certain statistical level for hospitals of similar and comparable locations. "Routine costs" for this purpose generally include the hospital's cost of providing room, board and nursing services to the patient. These "routine cost" limits are also applicable under the California Medi-Cal program (Welfare and Institutions Code, Section 14106a) as well.

The specific limitation imposed in 1974 was set at the 90th percentile of the routine costs of the group of similar hospitals, plus 10 percent (10%) of the median of the routine costs of those facilities. Hospitals whose routine costs exceeded that level were deemed "inefficient" and were not entitled to the remainder of their routine costs over the limitation unless they qualified for one of several exceptions. Those hospitals at or below the 90th percentile plus 10 percent (10%) of the median were deemed "efficient" and suffered no reimbursement disallowances.

Over the years, the statistical level for "efficiency" was lowered gradually, but surely. By 1978, the limit was the 80th percentile plus 10 percent (10%) of the median. Thus, the Secretary's definition of efficiency changed from year to year, and hospitals operating quite efficiently one day could be deemed inefficient overnight as new statistical limitations were issued.

During the years 1974-78, Los Angeles County hospitals confronted no significant problem under Medicare's routine cost limitations.

On March 1, 1979, the Secretary published in the Federal Register (44 FR 11612) proposed modifications to the Medicare routine cost limitations. In significant respects, the proposal altered the approach to calculating "routine costs" and lowered the statistical limitation to the 80th percentile, eliminating the additional "10 percent of the median" factor.

On June 1, 1979, the Secretary issued final regulations in the Federal Register (44 FR 31806) imposing new routine cost limitations, effective July 1, 1979. These guidelines created a new statistical standard at 115 percent (115%) of the mean, in lieu of the 80th percentile ceiling proposed on March 1. The statistical standard for Fiscal Year 1980-81 was 112 percent of the mean cost for each hospital size group plus adjustment factors. Los Angeles County hospitals lost $4.3 million as a result of these new cost limitations. On October 1, 1981, this was further reduced to 108 percent of the mean. In addition, the nursing differential allowance was reduced from 8½% to 5%. Our loss due to these reductions is estimated at $5.6 million for 1981-82.

Thus, by means of the new Medicare routine costs limits, County hospitals have been transformed from an "efficient" status under Medicare and Medi-Cal to a system facing significant losses and accompanying reductions in services and programs.

MEDI-CAL

Medi-Cal is the California version of the 53 Medicaid programs in the nation (49 states, three U.S. territories and the District of Columbia). The program is best defined by Section 14000 of the California Welfare and Institutions Code as follows:

> "The purpose ... is to afford health care and related remedial or preventive services to recipients of public assistance and to medically indigent aged and other persons ... The intent of the Legislature is to provide ... for health care for those ... persons who lack sufficient annual income to meet the costs of health care."

Medi-Cal costs have been rising at a rate of approximately 20 percent (20%) per year over the past decade. State dollars supporting the program increased 900 percent (900%) between 1967 and 1978. In contrast, during the same period, the U.S. medical care Consumer Price Index rose 119 percent (119%). The program cost the State $210 million in 1967 and by 1978, the amount reached almost $2 billion.

Medi-Cal is now the single most expensive program in the State budget, and will cost $4.7 billion in Fiscal Year 1981-82, which is a cost overrun of over $200 million.

Several attempts to restructure and constrain the rising costs of the program in recent years have been tried by the Administration through its regulatory authority and by the California Legislature through budget and legislative redress.

The State initially established regulations for cost reimbursement limits for hospital inpatient services in 1975. The limit would be increased about 10 percent each year and be applied on a cost per day basis. However, the regulations were overturned by court action because the State did not follow the proper Federal approval procedures and failed to make the system flexible enough to account for the many differences in the hospitals. The State prepared a new regulation (Title 22, Section 51536) early in 1980, held public hearings, received Federal approval, and made the regulation effective on July 1, 1980.

The new Medi-Cal regulation will reimburse hospitals for inpatient services on the lower of 1) customary charges, 2) allowable costs using Medicare standards, or 3) an all-inclusive rate per discharge.

Each year the State will compute a rate per discharge for each hospital which, when multiplied by the number of Medi-Cal discharges, will determine the total dollar limit for reimbursable costs. The rate per discharge will be adjusted by a market basket classification on goods of services purchased by hospitals, a corresponding set of market basket weights, and a related series of price indicators. The hospital cost index will then be adjusted by a volume adjustment formula and a case mix allowance.

The State has recently adopted a new regulation, Section 51537, which will further reduce Medi-Cal reimbursement for hospitals with an annual average bed occupancy rate less than 55 percent of its licensed bed capacity. Several of our hospitals were forced to reduce their number of licensed beds to avoid a potential loss of $7.3 million. This action, required to preserve current levels of reimbursement, has the potential for serious consequence should these beds be required in the future.

The State is also in the process of adopting Section 51538, a new regulation which will impose a 6 percent ceiling on increases in Medi-Cal payments for inpatient hospital services during the 1981-82 fiscal year. We estimate that county hospitals will lose almost $12 million in Medi-Cal payments as a result of this 6 percent limit.

UNDOCUMENTED ALIEN HEALTH CARE COSTS

In assessing the financial status of the County's hospital system, it must be recognized that it is the only system required to care for the indigent and available to the County's rapidly escalating number of undocumented alien residents. The Census Bureau conservatively estimated that one million persons in the latter group, the majority of which are from Mexico, are now living in Los Angeles County.

One out of every five inpatients at a Los Angeles County Hospital is an undocumented alien, and the net cost for providing services to this population in County hospitals in Fiscal Year 1978-79 was approximately $91 million. We estimate our net expenditures in this category to exceed $120 million this year.

CAPITALIZATION NEEDS

Many of the remaining public-general hospitals in California are in desperate need of renovation and reconstruction. Proposition 13 negated the ability to issue general obligation bonds to finance needed construction. Revenue bond issues are possible, but complicated due to the fact that county health services generally run at a loss because of the county's statutory responsibility to provide care to indigents. Consequently, revenue sharing and County General Fund dollars are the primary sources for financing needed projects.

The LAC-USC Medical Center best represents Los Angeles County's needs in this area. The General Hospital Unit, which has over 1,300 beds, was opened in 1933. The facility was constructed pursuant to the standards and state of the art for providing hospital care in that era. Almost 50 years later the facility is still in full service and in need of over $9 million of identified and cited accreditation and licensing physical plant corrections. Financing these corrections and other needed hospital renovation projects would strain limited resources.

RECOMMENDATIONS

There are no simple, quick-fix solutions to any of the problems discussed in this presentation. Certainly a coordinated and cooperative effort between each level of government will be required to effectively resolve these complex issues. Your Committee might, however, consider the following Federal actions leading toward their resolution:

1. Establish county health service systems which function as providers of the last resort as a special category in State and Federal law. Special treatment should be accorded to these last resort providers in matters related to administrative procedures, cost control, hospital aid and Medicaid/Medicare reimbursement.

2. Exempt public providers from Federal regulations that negatively effect Medicare and Medicaid reimbursement, specifically 42 CFR 405.460 and 42 CFR 447.262.

3. Extend Medicaid and Medicare coverage to persons on the basis of medical and economic need irrespective of the legal status of the applicant's residency in the county providing treatment.

4. Facilitate the passage of legislation through the next Congress similar to H.R. 7908 (Stokes) and H.R. 7776 (Rangel) that would assist financially distressed hospitals and foster the development of experimental/alternative delivery and reimbursement models.

5. Authorize and finance a facility survey of the nation's public-general hospitals to assess construction or renovation needs and costs. Subvene costs based on this survey assessment.

6. Increase Federal funds for nursing schools and nursing student aid programs.

7. Support the retention of revenue sharing with local governments.

I appreciate the opportunity to present these concerns and recommendations to your Committee and trust that this presentation assists you in your efforts to support public-general hospitals.

Very truly yours,

Paul J. Drozd

Paul J. Drozd
Executive Director

PJD:kvr

Attachments

cc: Robert W. White
Jan Pollard

ATTACHMENT I

LICENSED HEALTH AND COMMUNITY CARE FACILITIES OPERATED BY THE DEPARTMENT OF HEALTH SERVICES, COUNTY OF LOS ANGELES
(Including Bed Categories and Services)

Health Care Facilities (General Acute Care Hospitals)

		Special Permit Services								Supplemental Services																				
FACILITY	MEDICAL/SURGICAL	Cardiovascular Surgery	Comprehensive Emergency	Basic Emergency	Radiation Therapy	Renal Transplant Center	Psychiatric	Burn Center	Intensive Care Newborn Nursery	Perinatal	Pediatrics	Intensive Care	Coronary Care	Rehabilitation	Acute Respiratory	Skilled Nursing (SNF) (Distinct Part)	Chronic Dialysis[1] (stations)	Dental	Nuclear Medicine	Occupational Therapy	Outpatient[2]	Physical Therapy	Podiatric	Respiratory Care	Social Services	Speech Path/Audio	TOTAL LICENSED BEDS[3]	FUNCTIONAL BEDS[4]	BUDGETED BEDS
LAC/USC M.C.	1424	x	x		x	x	166	40	48	157	164	90	16				(10)	x	x	x	x	x	x	x	x	x	2105	2105	1569
RANCHO LOS AMIGOS H.	489											24		456				x	x	x	x	x		x	x	x	969	836	637
HARBOR/UCLA M.C.	495	x		x	x	x	39		18	62	37	47	10		8		(6)	x	x	x	x	x		x	x	x	716	585	450
LONG BEACH GEN. H.	241											8				53		x		x	x	x		x	x	x	302	210	125
M.L. KING, JR. G.H.	245	x		x			(76)[5]		10	60	54	29	6				(6)	x	x	x	x	x		x	x	x	404[5]	400	300
MIRA LOMA HOSP.	135															72		x			x	x	x	x	x		207	118	117
OLIVE VIEW M.C.	70			x			36[6]				8	9					(9)	x	x	x	x	x		x	x	x	123[6]	115	107
TOTALS	3099						241	40	76	279	263	207	32	456	8	125	(31)										4826	4369	3305

Community Care Facilities (Social Rehab Facilities)

Acton Rehabilitation Center - 309 beds[7]

Warm Springs Rehabilitation Center - 199 beds[7]

Comments:
- (1) Dialysis stations - not licensed beds
- (2) Includes ambulatory care centers licensed under each hospital
- (3) Does not include holding or E.R. beds or Newborn Bassinets
- (4) Available for immediate use
- (5) 76 psychiatric beds approved by SDHS - will be on forthcoming license bringing total to 480 licensed beds
- (6) 26 additional contracted Psychiatric beds at San Fernando Comm. Hospital (not on OVMC license).
- (7) Dispensaries in these facilities licensed as outpatient services under Olive View Medical Center

Note: An "x" indicates an approved special permit or supplemental service for which the State does not designate beds.

HDK/sf
8/1/81

Attachment II

DEPARTMENT OF HEALTH SERVICES
SCHEDULE OF HOSPITAL EXPENDITURES AND REVENUES
FOR FISCAL YEAR 1980-81

	LAC-USC MC	H-UCLA MC	MLK	RLAH	OVMC	LBGH	MLH	TOTAL
Patient Statistics								
Average Daily Census	1,321	385	278	496	112	149	99	2,840
Inpatient Days	482,196	140,403	101,624	180,993	40,954	54,266	36,142	1,036,578
Admissions	82,694	23,118	21,679	6,917	5,362	3,250	1,733	144,753
Births	13,999	4,345	5,402	0	0	0	0	23,746
Outpatient Visits	489,865	199,448	195,996	49,828	102,013	31,701	21,803	1,090,654
E.R. Visits	164 432	58,695	36,754	0	0	0	0	259,881
Operating Expenditures								
Salaries	$175,203,779	$ 55,642,450	$ 48,891,981	$44,530,547	$22,655,278	$10,252,846	$ 7,602,049	$354,778,930
Employee Benefits	40,779,984	13,013 589	11,599,938	11,880,282	5,438,000	2,819,126	1,787,624	87,318,543
Services & Supplies	90,130,764	35,554,963	36,550,262	25,499,806	11,544,163	4,407,407	4,548,395	208,235,760
Other Charges	823,853	102,239	226,114	646,169	63,145	309	14,979	1,876,808
Depreciation	4,085,217	1,019,700	3,667,267	1,426,624	1,559,871	216,199	222,938	12,197,816
Total	$311,023,597	$105,332,941	$100,935,562	$83,983,428	$41,260,457	$17,695,887	$14,175,985	$674,407,857
Operating Revenue								
Medi-Cal	$ 86,139,133	$ 36,580,441	$ 29,632,571	$34,558,443	$ 9,493,594	$ 5,449,702	$ 5,816,961	$207,670,845
Medicare	36,373,804	12,056,463	9,430,162	12,622,705	3,122,273	1,888,190	2,611,678	78,105,275
Self-Pay/Insurance	22,437,792	12,371,539	4,123,837	10,651,292	2,045,720	918,581	713,254	53,262,015
Services to Other County Funds	28,097,344	6,044,263	6,792,487	2,333,253	8,466,525	618,685	444,943	52,797,500
AB-8	40,621,490	11,305,657	15,643,875	7,756,207	6,310,134	0	1,971,917	83,609,280
PFCW	3,567,201	936,781	790,562	390,319	653,365	238,675	254,614	6,831,517
Other	2,859,600	690,485	325,718	291,434	124,629	62,558	67,681	4,422,105
Total	$220,096,364	$ 79,985,629	$ 66,739,212	$68,603,653	$30,216,240	$ 9,176,391	$11,881,048	$486,698,537
County Contribution	$ 90,927,233	$ 25,347,312	$ 34,196,350	$15,379,775	$11,044,217	$ 8,519,496	$ 2,294,937	$187,709,320

DP:amg
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ATTACHMENT IIa

DEPARTMENT OF HEALTH SERVICES
CATEGORICAL BREAKDOWN OF HOSPITAL BOARD ADOPTED REVENUES AND NET COUNTY COST - FISCAL YEAR 1981-82

TOTAL	LAC/USC/MC	H/UCLA/MC	MLK	RLAH	OVMC	LBGH	MLH	TOTAL
Budgeted Expenditures	$325,193,147	$112,312,497	$113,027,500	$95,446,446	$40,583,660	$9,844,629	$16,090,865	$702,498,744
Less: Operating Revenue								
Medi-Cal	$107,955,877	$ 44,026,365	$ 37,527,689	$37,817,560	$10,554,428	$5,249,810	$ 5,711,882	$248,843,611
Medicare	38,603,433	13,162,771	8,038,434	14,093,697	3,458,371	555,696	2,889,330	80,801,732
Self-Pay	7,502,971	2,613,708	3,088,749	1,524,066	770,362	56,323	69,853	15,626,032
Insurance	14,352,086	10,172,736	951,914	10,694,104	1,269,252	250,119	146,495	37,836,706
Svcs. Other County Funds	32,174,524	6,049,313	17,805,105	1,407,119	8,502,364	270,079	934,839	67,143,343
Government Aid	3,675,578	1,094,304	666,842	268,194	727,018	81,652	274,825	6,788,413
Other	3,452,311	1,355,395	380,304	338,400	122,494	32,066	8,596	5,689,566
Totals	$207,716,780	$78,474,592	$ 68,459,037	$66,143,140	$25,404,289	$6,495,745	$10,035,820	$462,729,403
AB-8/Revenue Sharing/County Contribution	$117,476,367	$33,837,905	$ 44,568,463	$19,303,306	$15,179,371	$3,348,884	$ 6,055,045	$239,769,341
Program Reimbursement Limitations								
Non-Medically Necessary	4,453,221	1,334,197	646,272	838,757	296,723	244,231	172,866	7,986,267
Non-Covered Service	790,803	213,417	4,889	117,170	91,413	618,278	37,635	1,873,605
1981-82 State Budget Cuts	6,208,272	2,728,291	2,260,496	2,162,549	590,196	273,725	336,471	14,560,000
Inpatient Reimbursement Rate Limitation	12,131,270	2,255,100	4,115,590	4,235,235	1,065,255	465,536	510,390	24,778,366
Outpatient SHR Limitations	11,091,193	2,296,937	9,476,176	1,158,082	743,925	895,374	936,533	26,598,220
Sub-Total	$ 34,674,759	$ 8,827,942	$ 16,503,423	$ 8,511,793	$ 2,787,512	$2,497,144	$ 1,993,895	$ 75,796,458
Program Ineligibility								
Medi-Cal Share of Cost	$ 672,267	$ 262,819	$ 227,557	$ 233,532	$ 58,786	$ 27,674	$ 30,791	$ 1,513,426
Excess Resources	1,275,453	298,455	1,108,542	979,139	587,630	230,216	0	4,479,435
Outpatient Medicare Co-Insurance	1,235,456	478,788	577,904	503,811	161,528	85,783	178,141	3,221,411
Sub-Total	$ 3,183,176	$ 1,040,062	$ 1,914,003	$ 1,716,482	$ 807,944	$ 343,673	$ 208,932	$ 9,214,272
Unreimbursed Indigent Cost								
Resident Citizen	$ 32,127,912	$17,272,687	$ 13,897,478	$ 4,024,272	$ 6,564,696	$ 230,489	$ 1,058,728	$ 75,176,262
Resident Alien	603,219	237,633	140,294	4,257	115,734	62,450	988,674	2,152,261
Non-Resident	43,703,637	5,547,075	7,579,676	3,385,327	757,050	215,128	1,616,226	62,804,119
Sub-Total	$ 76,434,768	$23,057,395	$21,617,448	$ 7,413,856	$ 7,437,480	$ 508,067	$ 3,663,628	$140,132,642
Non-Chargeable Service Cost	$ 3,183,664	$ 912,506	$ 4,533,589	$ 1,661,175	$ 4,146,435	$ 0	$ 188,600	$ 14,625,969
Totals	$117,476,367	$33,837,905	$44,568,463	$19,303,306	$15,179,371	$3,348,884	$ 6,055,045	$239,769,341

12/29/81

D4/9/4

Chairman RANGEL. Mr. Newman is the chief operating officer, Parkland Memorial Hospital in Dallas. Thank you very much for making the trip.

STATEMENT OF RAY G. NEWMAN, CHIEF OPERATING OFFICER, PARKLAND MEMORIAL HOSPITAL, DALLAS, TEX.

Mr. NEWMAN. Mr. Chairman, Congresswoman Schroeder, members of the panel, good afternoon.

We have sort of a favorable story to tell about Parkland, because we have been able to turn it from a financial crisis into a financially strong position. However, we are not immune from the cutbacks and the impact that that will have with us.

Parkland is operated under the governmental authority of the Dallas County Hospital District in Dallas, Tex., and is the public general hospital for Dallas County, statutorily obligated to provide medical care for medically indigent patients in Dallas County.

In addition, it is the major emergency medical center for the area and is the primary teaching hospital for the adjacent University of Texas Southwestern Medical School. Approximately 350 resident physicians under the supervision of the medical school faculty are employed by the hospital. Parkland also serves as the clinical training site for many nurses, medical technologists, and more than 14 types of health care and allied health specialists.

Parkland is a major medical research center and provides many sophisticated medical services such as major burn care, kidney transplants, trauma intensive care, high-risk maternity care, and advanced diagnostic procedures generally not available elsewhere in the community. Because of its many responsibilities and roles, Parkland is a major community resource and investment that directly or indirectly affects the lives of virtually every resident of Dallas County.

A few statistics indicate the staggering volume of direct services that the hospital provides annually: 218,000 outpatient clinic visits, 175,000 emergency room visits, 32,000 admissions, plus 9,000 newborn admissions. Since about 75 percent of Parkland's patients are admitted through the emergency room and most of the hospital's patients are socially and economically disadvantaged, the medical services that are needed are wide-ranging and intensive.

During the late 1970's, Parkland, like many other public general hospitals then and now, was plagued by inadequate financial support and a loss of public confidence. The hospital, Parkland, suffered annual cash deficits ranging from $1 million to $9 million due to inadequate operating funds. The hospital continued operating during these times by using bank overdrafts, by delaying payments to vendors, and by deferring or cancelling major equipment purchases. During these years, employee morale plummeted. The physical appearance of the hospital deteriorated. Employee turnover, especially among nurses, soared and the quality of patient care declined noticeably. The hospital administration at that time appeared unresponsive to the community and the hospital projected an increasingly negative image. The institution was frequently the target of attacks and criticism in the news media and in other public forums.

The emergence of new political leadership in the county in 1978 and 1979, set the stage for dramatic reversal of these ominous trends. The county commissioners court has appointed a new strong hospital board and gave the board a mandate to effect certain changes in the management and administration of the institution.

In January 1980, the hospital board and newly reorganized administration joined forces with the medical school and business leadership and many community groups to win overwhelming voter approval for an $80 million-bond issue to renovate and expand the hospital. Construction work is now underway on the project which will increase the number of hospital beds from 750 to 940, and double the capacity of the outpatient clinic.

The financial picture has also brightened dramatically. The hospital has implemented better budgetary management, more effective billing and collection procedures, a comprehensive cost containment program and a productivity analysis and reporting system, which helps provide a most effective and appropriate allocation of personnel. These are just a few of the measures taken. Parkland, incidentally, now ranks in the top 15 percent of large general hospitals in Texas in terms of productivity and this is according to the recent analysis by experts from the Texas Hospital Association. Improved financial management plus adequate tax support has enabled the hospital to eliminate the cash deficits of previous years and to end the last 2 years with healthy excesses of revenue over expenses.

There is now not only enough money to meet all current obligations and remain competitive in the marketplace for skilled health care professionals, but also money to reinvest in plant and equipment. This latter point means that the skilled employees will have the tools and facilities they need to deliver high quality care to the patients.

Last summer, as a testament to Parkland's much-improved financial condition, the first increment of bonds for the hospital's building program received the highest bond ratings ever for a hospital district in Texas.

Furthermore, through an aggressive community relations program spearheaded by the chief executive officer, Parkland's image in the community has improved markedly as have relations with the news media. The hospital's efforts to attract private donations and contributions are already showing significant results. Legislative efforts have paid off, as well.

In the last session of the State legislature, Parkland allied itself with other major teaching hospitals in the State and won passage of enabling legislation to provide state subsidies for the training of resident physicians. We and the other teaching hospitals will seek funding from this legislation in the next session of the legislature.

In summary, at a time when public hospitals around the country are in deep trouble, Parkland stands out as an institution strongly supported by the community it serves. The institution's future has never looked brighter.

That's the good news.

The dark clouds on the horizon form from the new trend of receding Federal support for health care and social services, coupled with steadily increasing need and demand for these services and continuing rise in cost of providing them.

Contraction of the already-restrictive Texas medicaid program has resulted in the loss of benefits for 65,000 recipients in Dallas County. Community health center funds have and are being eliminated for some programs in Dallas, with 2,000 families already facing uncertainty over the continuation of health services in their community. Many other federally-supported health centers are in jeopardy, causing concern on the part of thousands of other families in Dallas about future access to medical care.

Many community residents concerned about the closure of these facilities naturally are turning to Parkland for financial support. But the hospital district at present has no money available to support additional satellite operations and could not do so without increased tax support. If the hospital district were forced by political pressure and new legislative and regulatory conditions to fill the void without additional tax support, the hospital's financial position would be quickly eroded and the institution would fall back in the quagmire of the prior years.

Just as other community programs are facing the loss of funds, Parkland faces the loss of some of its own funding sources in medicaid and medicare cutbacks. Reductions in medicaid and medicare reimbursement as currently proposed would cost Parkland at a minimum $1 million annually. In addition, more restrictive eligibility requirements for these Federal social safety net programs will likely force some patients to seek free care at Parkland instead of going to private hospitals closer to their homes. In such a situation, Parkland could easily become a dumping ground for all medicaid patients, and although the Dallas area economy is relatively strong now compared to the rest of the economy in the country, the great influx that we are now seeing of job seekers from other parts of the country will mean a corresponding increase in the need and demand for health and social services. Many social service agencies in the Dallas area are already feeling the impact of this in-migration.

As the central referral facility and emergency medical center, Parkland will always be the key component of any comprehensive system of publicly-supported health care in Dallas County. It is essential for the wellbeing of the community that Parkland remain financially strong and have the resources it needs to carry out its responsibilities effectively and in a dignified, humane manner.

While the hospital is committed to the concept and practice of cost containment, it is also committed to offering the state of the art, high quality care. Yet, at the same time there are major economic forces, such as the increasing cost of skilled health care personnel, the increasing costs of advanced medical technology, increasing energy costs and other increasing operating costs that are beyond the hospital's control. The increasing median age of the Dallas area population by itself will mean an increasing demand and need for medical services.

The impact of implemented and proposed Federal program reductions can and will have an adverse affect on the ability of Parkland to deliver quality care to the patients who desperately need its services.

Unless local support is generated to fill the void left by Federal cutbacks, men, women, and children will suffer and perhaps die because of inadequate, untimely or absent medical care. If Parkland's financial resources continue to melt away, the hospital will be forced ultimately to ration care, providing it only to those most urgently in need. The hospital will find itself in a deadly tailspin from which it may never pull out.

The sad paradox, of course, is that all these proposed so-called economies are false economies and will in the end cost everyone more; more in terms of lost productivity, more in terms of human misery and all that connotes, more in terms of the deterioration of a vital community facility. The taxpayers will pay more in interest expense for Parkland's construction bonds because the hospital district's bond rating will undoubtedly suffer in such a situation.

In short, it is easy to foretell what will happen as public general hospitals such as Parkland steadily lose their financial support because Parkland and many other hospitals have already been in that position. I can assure you that everyone—the patients, the hospital personnel and the community—suffers when the public general hospital is unable to carry out all of its many responsibilities.

In the final analysis it may be true that medical care for the disadvantaged residents of a community is mainly the responsibility of that community. In fact, Dallas County taxpayers already provide 55 percent of Parkland's operating revenues. We intend to make every effort to educate the residents of Dallas County about the need for a strong, viable Parkland Memorial Hospital. Much can be done in this respect and we believe that the people of Dallas County are beginning to recognize that a strong Parkland, a Parkland everyone can be proud of, is a community asset, not a social burden.

But the Congress of the United States determined less than 20 years ago that ensuring the adequate medical care of our elderly and disadvantaged fellow Americans is a joint responsibility of the Federal, State, and local governments. It would be disastrous for the Federal Government to cripple a system of publicly supported health care which has saved and improved the lives of millions of Americans. These programs were initiated because the private sector was unable or unwilling to provide these services in the past. It is foolhardy and reckless to think the private sector will fill the vacuum now to provide care for the poor.

This concludes my testimony. Thank you for the opportunity to express our concerns.

Ms. SCHROEDER. Mr. Chairman, I want to apologize. I was at a meeting and I must say that the chairman and I were on the other side of several young Turks who were from Texas in our party, who told us there were no problems in Texas, so I have been waiting to find out how Texas did it. I hope you talk to those young Turks. We have tried to. They told us they had it under control down there and "we didn't need Federal funds anymore."

Thank you very much. We thank the panel, and I will see you later.

[Congresswoman Schroeder left the proceedings.]

Chairman RANGEL. Thank you so much.

Mr. Roberts, the last time you testified before this committee you were in bad shape at Parkland and I hope that we have the same type of good news from Cook County. Someone maybe struck oil there. [Laughter.]

Mr. ROBERTS. Coal would be more like it in Illinois.

STATEMENT OF ELLIOT ROBERTS, EXECUTIVE DIRECTOR, COOK COUNTY HOSPITAL, CHICAGO, ILL.

Mr. ROBERTS. Thank you, Mr. Chairman, for the opportunity to present before the committee today. I am going to be brief because I believe that really most of the information you are hearing is not new. But still, I know you need to hear it from us.

For the record and the background, Cook County Hospital is a 1,400-bed general hospital operated in Chicago, owned by the County of Cook. The county of Cook has some 6 million population. While the hospital sits in Chicago, it services the entire county. However, the bulk of the patients do come from Chicago. The population there is about 3 million, with about 60 percent being black and 60 percent probably being of the poor.

The State in its plan to meet its own budget obligations decided to reduce the medicaid funding by some $2 million, effective as of July last year. As a result of that, we began to see within our hospital major transfers of patients as a result of their inability to qualify for financial reasons within those voluntary hospitals.

To speak a minute on the issue that you raised earlier, in terms of what do we as public hospitals do in terms of what the voluntary hospitals refer to us, if you will, by way of patients who can't pay, it has some relevance to the point was made by Mr. Drozd in terms of the fact that we are looking at the Federal level in terms of competition. I would have you understand that a private hospital is a corporate entity and it has responsibilities to its board as a corporation. How, that's not to say that those institutions do not, in fact, treat the poor. But the problem is and the fact is that the public hospital stands statutorily as the institution to care for the poor. As the Federal Government developed initially the medicaid and medicare programs and said that patients have the free choice to go to the institution or that provider for care and the moneys were there, and the doors opened up because I have got statistics to reflect for you that in 1968, Cook County Hospital was serving some 2,500 patients a day and the admissions were running 76,000. In 1981, those admissions are running 37,000, and we are operating some 1,300 beds, actually operational beds.

Now, the change came as a result of the advent of medicare-medicaid. When the Federal Government and the State said, "We will pay," patients were welcome in the voluntary sector, and those patients left the public sector.

When the Federal Government is now saying, "We are not going to pay you as much for those same patients," now those patients are coming back. They didn't take them before when you weren't paying and now that you are going to reduce that payment, then those patients are going to return to us in larger numbers.

Let me go through these notes briefly and I did not bring a written copy, but I will send one back to the committee.

As has been noted before but too often not heeded are the following: The Government does have the responsibility for the health and welfare of its citizens. This was recognized in the establishment of titles XVIII and XVIV. The institutional providers of services have never been fully compensated due to the methodology used to calculate reimbursement.

In the meantime, the controls instituted which were intended to reduce the increase in the cost of health care have not to date proven to be successful. At this juncture, and absent the success of the earlier measures to reduce Federal spending, the current plan is to arbitrarily reduce the required funding by altering the various aspects of the program and the reimbursement formula.

Everyone recognizes that the unrecovered costs then become a financial burden to the institutional provider. This is going to be true whether that unrecovered cost is put on by way of limitation or whether it is in the form of a copayment by the patient which was already spoken to in terms of all it does is to increase the bad debt within the institution because the patients who come cannot, in fact, pay.

It is also recognized that it will affect providers differently and this will depend upon the patient mix, both in terms of the illness as well as the payer class served.

My concern today is for the large teaching hospitals, largely public hospitals, which are bearing the responsibility both for caring for the poor in large numbers and again, as was mentioned earlier, for the medical education programs of the medical staff and allied health personnel. Both of these responsibilities are directly related and, in fact, are interrelated, interdependent, because absent the availability of the physicians in training to provide the care, many of our public hospitals would not, in fact, be able to function.

In addition to recognizing those community hospitals find it difficult to cope with financial shortchanging, as I describe it under the new regulations, additional patients will, in fact, seek their care from the public hospitals. The public hospitals will then be treating larger numbers of patients with less money to pay for their care. This will only exacerbate an already overburdened system at the local level.

Of critical concern to me today as the director of Cook County Hospital is that section of the Reconciliation Act which has to do with the medicare limits on hospital per diem in patient routine costs. Because that one alone for Cook County is going to cost us as we are projecting our 1982 budget something between $11 and $15 million, and you are probably familiar with the fact that what, in fact, has happened is that they have modified this from 112 percent of costs within the mean to—from 112 to 108 percent. In 1980, when it was at 80 percent, the impact was $500,000 for Cook County. In 1981, when it was at 112 percent, the impact was $4 million. In 1982, given consideration of our current budget that we are preparing, the impact is going to be about $11 to $15 million.

When one considers the fact that for a hospital like Cook where for 10 years prior to 1979, there was established an authority, the Health and Hospitals Governing Commission, and the governing commission had to go to the county to obtain its funding and the cost of the operation continued to escalate without the funding being available from the county. There was a decision to dissolve the commission at the State level and return the responsibility to the county and at that time the county found itself with some $90 million worth of deficit which it had to recover. In order to do this, the millage on real estate, which was applicable to the health facilities, was doubled and in addition to that, a 5-cent tax was added to cigarettes, all to help cover the operation of the health facilities.

When I speak of the health facilities, I am thinking of Cook County Hospital, Cermak Hospital and Oak Forest Hospital, which was three institutions which the county was responsible for, in addition to some five satellite clinics.

Chairman RANGEL. Was that done by legislation?

Mr. ROBERTS. It was done at the county level by referendum, ordinance, whatever is appropriate at that level.

Chairman RANGEL. Did the citizens vote for it themselves?

Mr. ROBERTS. Yes, they did.

Chairman RANGEL. Now, the thing that I am saying is that from 1979 until now, the county has been able to erase the deficits that had built up over the previous 10 years, managed to get some stability within the work force, and hold programs together. Employees were working who had not received increases in some 3 or 4 years. There had been layoffs and reductions in service.

Just as we are about to get some stability in the total operation, now we are looking at facing these kinds of cutbacks which had previously been anticipated to be a major part of the revenue generation in terms of our medicare and medicaid workload.

All I am saying is that it is going to be difficult for the county now to recover and to maintain any continuing positive thrust in light of the Federal position, as well as the State's position. Consider again, if you will, that Illinois has an unemployment rate of 8.4 percent and the only reason why it is lower than the national level is because the national level went up to 8.9 in December. When you put all those pieces together, it can only speak to some potential need for additional revenue through taxes at the county level, which is going to be a bitter pill to swallow when one considers what just happened 2 years ago.

Thank you, sir.

Chairman RANGEL. Again, let me congratulate each and every one of you for coming together to see whether or not you can come forward with some solutions to what is a crisis and what is a serious problem.

It is important that we all understand the legislative process and I hope that I'm wrong but I just don't have the impression that you are any stronger politically this year than you were last year. I don't know what you're going into at the conference and I don't know what your committees and subcommittees are all about, but I know I will be listening carefully to see what comes out of it.

I don't think I can accept the same type of language as to what is a public institution. It is clear to me that there is no place for anyone to go except you. But I am on the tax-writing committee, this is the tax-writing committee. We not only deal with medicare and social security and SSI, we deal with tax exemption and I can't believe that any agency or organization that receives tax exemption doesn't have a public responsibility. I can't believe that any teaching institution that is able to use the public hospital system doesn't have some responsibility and it could very well be that your institutions have no place to send the patients. But I get the clear impression that if you close down, there won't be any public uproar from your consituencies. Most of them are poor and I get the clear impression that most of them are minorities. So we are dealing with a national recovery package but if it fails, most Americans won't feel the pain and the impact.

Am I wrong? I mean, does anyone—am I seeing this unclearly?

Mr. ROBERTS. You are absolutely right.

Mr. DROZD. You are absolutely right, Mr. Rangel. We have experienced severe cutbacks in Los Angeles County this year in health services. We have an anomoly in legislation out there that is called the Belinson [phonetic] Act. Our board of supervisors is required to hold public hearings and make a finding of fact that there is no detrimental impact, curtailment or closure of health care programs in the counties.

Our board made such a—held such hearings and made such a finding in time to put curtailments in place in July. We have been in the courts since July and as a result of these court actions which have prevented us from making some curtailments, we are currently running somewhere around a $30 or $40 million deficit in our programs. So there is a constituency but in all honesty, I anticipate that that whole effort will lose. We will be faced with making up that $40 million deficit over a shorter period of time. So you are right. We have talked about the competition model and I can assure you there is no competition for the socially and economically undesirable patient.

Chairman RANGEL. But we have reached where we are, not because of public hospitals, but because of all you good people trying to expand the quality of medical coverage even for people they didn't want to touch themselves. But still, once you could show that doctors would benefit, hospitals would benefit and everyone came together even though the public hospital carried the brunt, the movement had the strength.

You talk about national health insurance. We hear doctors, everybody, as long as the bucks are there, they support any program. But it should be important, at least in the layman's dialog, because sick persons that are looking for help don't have the sophistication, nor should they try to distinguish between a public hospital and a nonpublic hospital or charitable hospital or a voluntary hospital or not-for-profit hospital. I would hate to see what happens in our towns when people lose their loved ones because their loved ones couldn't pass the wallet biopsy, whatever it's called, and they refer him to a public hospital that is no longer in existence or has been forced to partially or in whole close its service.

We heard in Memphis from a public hospital official that if you only have one oxygen tank and two kids need it, a decision has to be made. That's pretty rough but we are hearing it all over the country and I do hope that you are able to reach out to assist us in bringing in additional people.

Ms. Schroeder was specifically talking about a number of members from the congressional delegation representing the sovereign

State of Texas. When the votes are counted, at least we would like to believe that you know where your Members of Congress are when they voted. I don't want to turn this hearing into anything political.

Mr. ROSENBLOOM. Congressman, you are absolutely correct that we are in desperate need of allies and that the public hospitals by themselves as the only vocal representatives of the patients they serve will not fare well. That's one of the frustrations of those of us that are from large public hospitals in dealing with the large hospital associations because by and large, they are not affected by the negative cutbacks because, by and large, they don't carry the programs.

Chairman RANGEL. It doesn't have to be that way. Even politicians would rather not hear from you, you know. So why should people who are not affected want to hear from you? The easiest thing to do is to act like it doesn't exist. I am saying that unless the figures are produced in some way to show the number of people that finally reached your hospitals that were either turned away, denied service or referred from the private hospital sector, who would know? I refuse to believe that they are not a lot of good-thinking, religious and spiritual civic and community leaders that just don't know the problem exists because sick people are not out lobbying.

Mr. ROSENBLOOM. We can embarrass the private hospitals.

Chairman RANGEL. I don't want to use that word.

Mr. ROSENBLOOM. We can embarrass the private hospitals into taking——

Chairman RANGEL. I asked for statistical data; not an embarrassment.

Mr. ROSENBLOOM. Well, we can embarrass them to a point. We can embarrass them to, perhaps, 5 to 10 percent. In Boston, we can embarrass them to the point where they cannot and will not turn away somebody who is actually delivered in an ambulance.

Chairman RANGEL. My point is really—let me make my point abundantly clear—that there are enough deficits and enough poverty to pass around to all the private and public institutions, so it is not me trying to spread pain. I am merely saying that, once they know what their balance sheets will look like if you guys ever go out of business, they would be down here—not necessarily at the Public Hospital Association's conference, but certainly in Washington. I am not going to accept that their commitment to the sick should be any less because they are not designated as a public hospital. Nor do I believe that our religious organizations' should be silent during this crucial period. You know, I took one vow in Congress. It wasn't of poverty by choice, it wasn't to take care of the poor, the sick, the aged; I'm not trained to do it. But it just seems to me that in the last year, the only people that this committee has to hear from are the providers of the services that are being denied.

The reversals that could happen in this country, the disbanding of institutions, the dismantling of institutions that have taken years to build—who is going to be around to say that they didn't know where to testify or they didn't know what was going on or that they would like to see these things reinstituted?

So, please, I don't want to be preaching to the choir. I again want to reaffirm that. The fact that you have taken time to come down here and try to work out solutions is deeply appreciated by this Member, this chairman and this committee and I can count votes. I am only wanting you to know that you can depend on my support when you do reach out, not to embarrass, but to educate others as to what can possibly happen when that last door to health care is slammed.

In Chicago I know they know. I think it would be morally wrong to make a racial issue out of this, but a stranger to our town might find it a little strange that people of color are the ones not receiving health care and I'm sorry, but that's the question for us to explain to the unfree world.

Let me thank you very much for your testimony. The staff will continue to work closely with the association. I want you to feel free to call upon us if there is administrative redtape that you feel we can help you get through.

Mr. **Rosenbloom**. Thank you very much.

Chairman **Rangel**. The next panel is the panel on human impact. From the national health law program, from Los Angeles, Geraldine Dallek; Mr. Jake Whitecrow, executive director, National Indian Health Board; Hans Kleyn for Sister Mary Andrews, president, St. Joseph Hospital, Denver; Cathy Schoen, special assistant to the president, Service Employees International Union, Washington, D.C.

Thank you for your patience and we welcome your testimony. Let's see, Ms. Dallek.

STATEMENT OF GERALDINE DALLEK, HEALTH POLICY ANALYST, NATIONAL HEALTH LAW PROGRAM, INC., LOS ANGELES, CALIF.

Ms. **Dallek**. Thank you for inviting us to testify. I am from the national health law program, which is a federally-funded legal services corporation grantee, specifically concerned with improving health care access by this Nation's poor. Our clients are primarily users of public hospitals and these comments are made on their behalf.

You have heard much of the testimony on the impact of Federal cuts on public hospitals, and I don't really want to repeat what you have already heard.

Chairman **Rangel**. Your full statement will be placed in the record.

Ms. **Dallek**. Yes, and I do have a full statement.

I did want to make a point, though, about the private sector turning away poor people. We are beginning to see increased cases of private hospitals turning away medicaid recipients. Recently a for-profit San Diego hospital which is owned by American Medical International announced it was reducing from 20 to 5 percent the portion of medicaid patients that it would admit.

Additionally, a 1981 publication of the California Hospital Association entitled "Medi-Cal May Be Dangerous To Your Physical Health" made the not-too-subtle point that, "The more income a hospital gets from Medi-Cal, the more its financial health seems to deteriorate."

Maryland's hospitals, according to the Children's Defense Fund, are refusing to admit high-risk mothers for fear they will require care beyond the amount medicaid allows.

Last year, 28 States proposed or enacted medicaid reductions. This year that number will increase as States struggle to absorb Federal medicaid reductions. In addition, welfare cuts will mean that 810,000 poor children, 1 child in 9, will be eliminated from the program. Many of these children will also lose their medicaid coverage.

In addition, you have maternal and child health, and community health center cuts, all of which means that more and more poor people will go to public hospitals.

There are at this point in time no alternatives to the care provided at public hospitals. It is specious to claim as the present administration does that State and local efficiencies, innovation and the private health sector will make up for the Federal health cuts. This is either wishful thinking or a very cruel hoax. State and local governments suffering from recession and the impact of tax limitation measures cannot possibly reweave the holes in the safety net made by Federal health cuts. In domino fashion, Federal cuts mean State cuts and State cuts mean local cuts.

The voluntary sector will not make up for public sector losses. Indeed, private sector behavior exacerbates the plight of public hospitals.

Recently in San Diego, Children's Hospital announced that they have to drastically reduce the amount of charity care provided to poor children in San Diego. Since there is no local public hospital in San Diego and the only hospital is the university hospital which does very little in terms of indigent care, it is unclear where those kids will go.

The existence of the uninsured poor without money to pay for health care, the impact of Federal budget cuts and a private health care sector which treats the poor as pariahs are not the only destroyers of public hospitals. There seems also to be a mood in this country which the national administration so well embodies that it is no longer the responsibility of government—local, State or National—to provide help to those who cannot help themselves.

A corollary to this philosophy is that public is bad and private is good. This feeling or mood is being played out in the public hospital arena. In many communities local governments less able to protect, preserve, and promote public hospitals, are also less willing to do so.

Some local officials remain convinced that the provision of health care to the have-nots is a just responsibility of government. That is certainly clear in Denver. They are vigorously fighting to save what they can of their public institution. Unfortunately, other local officials are readily succumbing to budget pressures by cutting services, leasing, selling and closing their hospitals.

You've already heard about the budget cuts in Los Angeles County, $75 million were cut from the budget. Those budget cuts have devastated provision of health care in Los Angeles County. Additionally, the board has now proposed—board of supervisors—an additional $59 million cut.

Unbelievably, the board of supervisors has said there is no detrimental impact to the budget cuts. It is unbelievable and very difficult to understand how they could have come to that conclusion.

Chairman RANGEL. Detrimental impact on whom?

Ms. DALLEK. On the poor. To meet provisions of the Belinson Act they have to show there is no detrimental impact to the poor from their budget cuts.

Chairman RANGEL. I thought it was disproportionate.

Ms. DALLEK. No detrimental impact.

Chairman RANGEL. Under civil rights it was disproportionate, and they proved in New York that they were spreading the pain around equally.

Ms. DALLEK. No, it only has to be detrimental impact and given that, there are no longer pharmacist services; given that, several community clinics were closed; given that, there are $20 charges for all clinic visits now; and, given that clinic visits have gone up at least by 20 percent, it is very difficult to understand how they came to that conclusion.

Several other counties and cities have responded to the fiscal pressures by proposing to sell their hospitals. Boston, for example, reeling under the impact of proposition 2½ has proposed the sale of Boston City Hospital.

In Fresno County, Calif., the supervisors have proposed to sell Valley Medical Center—the major indigent care provider in the entire San Joaquin Valley. In Trinity County, the only hospital in the county is public and supervisors there also hope to sell their hospital.

The selling of public hospitals to for-profit hospital chains is a particularly ominous trend. One must ask why these chains covet public and voluntary private hospitals. Is it to serve the poor or is it to make a profit? Stories are surfacing about the alarming practices of private hospital chains when confronted with the poor who lack health insurance. I would be certainly happy to share with you those stories. For instance, Hospital Corp. of America hospitals in Georgia do not take in blacks and they do not take in medicaid recipients. Similarly for-profit hospitals in Nashville care for few poor people. I would be more than happy to share all that information with you.

Chairman RANGEL. The record will remain open for you to send that and I hope you send it to me personally, as well.

Ms. DALLEK. Absolutely.

I just want to very briefly talk about the impact of the closure of public hospitals.

Public hospitals, for example, are the major providers of obstetrical services for low-income women. In 10 States, more than 30 percent of all babies born during 1980, were cared for during gestation in public health department clinics. Alarmingly, we are already beginning to see the impact of Los Angeles County budget cuts and the imposition of charges on the delivery of prenatal care for poor women.

Dr. James Padbury, neonatalogist at Harbor General Hospital, reports that in December 1980, there were 2,000 prenatal care visits to 13 health centers. By May they had dropped to 1,300 visits a month. Since then, three county health centers have closed and it is clear that the number of poor pregnant women getting health care in the county is going to drop even more.

Dr. Bradbury also reports that there is a minimum of 165 percent increase in the women delivering babies at Harbor General Hospital in August and September 1981, who had had no prenatal care compared to the women who delivered babies in the hospital in August and September 1980.

Prenatal, delivery, and postnatal care is relatively inexpensive. A premature baby costs the county something like $78,000, on the average, and the institution for mentally retarded costs something like $13,000 to $20,000 a year. It is economically foolish not to provide prenatal care.

In Los Angeles County, infant mortality rates among blacks and Hispanics is very high. In Oakland, Calif., infant mortality rates among black poor women in Oakland are six times higher than among whites in the wealthy part of the city of Oakland. So in California, we have a very difficult problem about getting prenatal care for poor minority women.

Communicable disease control is another instance where the impact of county health service cuts will be felt immediately. TB rates last year increased in Los Angeles County by 30 percent, yet our county has decided to reduce the amount of TB care provided in the county by $424,000. I find this very difficult to understand.

I want to thank you for holding this hearing and I hope we can get some Federal assistance and I would like to say that we will provide you with all the information we can about private hospitals turning the poor people away.

Thank you.

Chairman RANGEL. Thank you very much.

[The prepared statement and a letter subsequently received follow:]

STATEMENT OF GERALDINE DALLEK
HEALTH POLICY ANALYST
NATIONAL HEALTH LAW PROGRAM

The National Health Law Program Inc. is a federally-funded Legal Services Corporation grantee specifically concerned with improving health care access by this nation's poor. Our clients are primary users of public hospitals. These comments are made on their behalf.

The threats to local publicly provided health care are many: Cuts in Medicaid and other federal health programs; an increasing number of uninsured poor; state and local budgets devasted by spending limitation measures and the recession; the for-profit hospital chain juggernaut, and; acquiesence in this Administration's judgment that public provision of service by its nature is "bad" and private is "good". Unfortunately, the local response to these threats has been distressingly similar. Across the nation, public hospital services are being cut, management responsibility turned over to the private sector, and public hospitals are leased, sold and closed.

Public hospitals have become the providers of last resort. The destitute, the elderly, the handicapped and minorities turned away from private health care providers have historically found an open door at the public hospital. If that door is shut, if the providers of last resort are gone, we will be left with a health care system in which tens of thousands, perhaps millions, of poor will have no where to go when ill.

I. The Impact of Federal Health Cuts on Public Hospitals

Over the last two decades the federal government has taken little or no interest in the plight of public hospitals. These facilities are owned, supported and run by local governments and thus have been considered local, not federal concerns. Nevertheless, federal policies directly affect the provision of locally funded health services and are largely to blame for the present crisis. Reductions in the 1982 federal health budget undermine the very existence of public hospitals across the nation. Present administration policies are destroying these facilities as surely as if they were hit by a neutron bomb; all we may have left are the shells of the structure---the employees, the patients and the equipment will all be gone.

A. Medicaid Cuts.

The one billion dollar federal Medicaid cut and massive state Medicaid reductions will put an added burden on public hospitals and clinics, a burden which they clearly cannot bear. First, county and city hospitals and clinics will receive, like all health care providers, less Medicaid reimbursement. But, because they are public facilities with a legal and moral obligation to care for the poor, they will not turn Medicaid recipients away as will private providers. Any reductions in Medicaid reimbursement rates, eligibility or services, will badly hurt hospitals and clinics. Cook County General, for example, estimates that federal and Illinois State Medicaid reductions will result in a loss of $24 million in the coming year. In California, the state has proposed only raising Medicaid hospital rates this year by 6% despite the fact that hospital costs went up 20% last year. Twenty hospitals in California provide care for 25% of the Medicaid Population---11 of these are county hospitals, 4 are California state supported teaching hospitals. Reimbursement cuts will thus have a disproportionate impact on California's county hospitals---at least those which are left.

Secondly, Medicaid cuts will result in more private physicians, private hospitals and teaching hospitals turning the poor away by "dumping" them on the providers of last resort. Indeed, this has already begun to happen. In Chicago, the private hospitals have developed plans to either stop entirely or severely curtail the care provided Medicaid recipients. A story in the Chicago Sun Times of September 20 recounts how private hospitals are lying to Cook County General in order to obtain tansfers for their Medicaid patients. In one instance, Billings Hospital asked to transfer a patient with blood pressure of 160/100 and a "strange" electrocardiogram. When the patient arrived at Cook County, the patient had a blood pressure of 270/150 and was vomiting blood. The patient died the next day.

Recently, a for-profit San Diego hospital owned by America Medical International announced it was reducing from 20% to 5% the proportion of Medicaid patients it would admit. A 1981 publication of the California Hospital Association entitled "Medi-Cal May Be Dangerous to Your Fiscal Health" made the not too subtle point that "The more income a hospital gets from Medi-Cal, the more its financial health seems to deteriorate." Maryland's hospitals, The Children's Defense Fund reports, are "refusing to admit high-risk mothers for fear they will require care beyond the amount Medicaid allows."

Thirdly, not only will public hospitals be asked to serve Medicaid patients the private sector turns away, they will also be inundated with indigents recently taken off the Medicaid rolls.

Last year 28 states proposed or enacted Medicaid reductions. This year that number will increase as states struggle to absorb federal Medicaid reductions. Several states have either proposed or eliminated whole groups of Medicaid eligibles. Medicaid changes in the Omnibus Reconciliation Act make Medically Needy programs especially vulnerable. In addition, Welfare cutbacks will mean that 810,000 poor children---one child in nine---will be eliminated from the program. Many of these children will also lose their Medicaid coverage.

B. Other Federal Health Cuts

Medicaid is not the only federal program whose budget cuts will negatively affect public hospitals. The Maternal and Child Health (MCH) Program suffered a 27% reduction this year. Much of the MCH money had gone to local health departments to provide prenatal and delivery care for women and primary care to poor children. This program is especially critical to the women and children who because of state income and eligibility restrictions are excluded from Medicaid. Last year alone, MCH programs provided services to 1 million pregnant women. A reduction in federal funds means less money available to local government to provide health services---prenatal care and primary care for children---absurdly destroying one of the foundations of a humane health care system. A reduction in MCH funds will also cost state and local governments in the long run. Alabama estimates that it saves $5 to $10 dollars in prevented illness for every one dollar spent on MCH services. In Mississippi it cost $1,100 to provide prenatal and delivery care and $20,000 a year for institutionalization for a child born mentally retarded because his/her mother did not get that care.

Community Health Centers serve the urban and rural poor living in medically underserved areas. This year's 25% reduction in the funding of these centers will, the National Association of Community Health Services estimates, mean the closure of 350 clinics. In many communities, these centers are the only alternative to crowded public hospitals outpatient and emergency rooms, and their loss will mean increased numbers of uninsured poor and Medicaid recipients seeking care at public facilities.

C. Lack of Alternatives to Federal Cuts

It is spurious to claim as the present administration does that state and local efficiencies, "innovation" and the private health sector will make up for federal health cuts. This is either wishful thinking or a cruel hoax. State and local governments suffering from recession and the impact of tax limitation measures cannot possibly reweave the holes in the "safty net" made by federal health cuts. In domino fashion, federal cuts mean state cuts and state cuts mean local cuts.

Public hospitals are to some degree inefficient. After all, they are underfinanced, undercapitalized, underequipped and understaffed. But we are losing these facilities not because of inefficiencies but because they care for the uninsured poor and no amount of "innovation" can change this fact.

Nor will the voluntary private sector make up for public sector losses. Indeed, private sector behavior exacerbates the plight of public hospitals. Private physicians and hospitals in increasing numbers refuse to treat Medicaid recipients and the uninsured poor. Only two weeks before Christmas, for example, Childrens Hospital in San Diego declared it would have to "drastically reduce" the amount of charity care it had been providing the city's poor children.

In spite of the President's call for voluntary action, neither the American Hospital Association, or American Medical Asociation have asked their members to provide more Medicaid and charity care.

II. The Impact of The Uninsured Poor On Public Hospitals

Medicaid covers only about one-half of the population living below the poverty line. There are 5 million children in this country without health insurance. Diana Dutton of Stanford University notes that some states in the deep South exclude well over 1/2 of their poor children from Medicaid coverage.

The problem of the uninsured poor is also especially acute in the sun belt states, the large urban centers of the Northeast and in communities along the migrant stream where undocumented immigrants live and work. For these immigrants, their only recourse when ill is the public hospital.

Undocumented workers come from third world countries and bring the diseases of poverty with them. It is critical that they receive care, if only to protect the public's health. Yet, though immigration policy is set at the federal level, the federal government during the last decade has been unwilling to confront the issue of services to this population. The health care of this population has been an unfair burden for local governments, and even the more progressive local governments are seeking to rid themselves of this albatross.

III. Local Government Response to The Public Hospital Crisis

The existence of the uninsured poor without money to pay for health care, the impact of federal budget cuts in health, and a private health care sector which treats the poor as pariahs are not the only destroyers of public hospitals. There seems also to be a mood in this country which the national administration so well embodies that it is no longer the responsibility of governments---local, state or national---to provide help to those who cannot help themselves.

A corollary to this philosophy is that public is "bad" and private is "good". This feeling or mood is being played out in the public hospital arena. In many communities, local governments less able to protect, preserve and promote public hospitals and clinic services are also less willing to do so.

Cities and counties are under increasing pressure to reduce or eliminate public hospital and clinic services across the nation. Some local officials remain convinced that the provision of health care to the "have nots" is a just responsibility of government. They are vigorously fighting to save what they can of their public institutions; other local officials are readily succumbing to budget pressures by cutting services, leasing, selling and closing their hospitals.

Los Angeles County, for example, has cut $75 million from county health services, closed eight clinics, reduced primary care at all the other clinics, closed one hospital and reduced the budget of two others by 20%, eliminated $1.5 million in drug prescriptions, most dental care, medical transportation, second trimester abortions, all clinic health educators, nutritionists and medical social workers. LA County is also now charging $20 for all clinic visits.

Several other counties and cities have responded to fiscal pressures by proposing to sell their hospitals. The City of Boston, reeling under the impact of Proposition 2 1/2, has proposed the sale of Boston City Hospital. Supervisors in Fresno County, California have sent out an RFP to several for profit hospital chains. They propose the sale of Valley Medical Center, the major indigent care provider in the San Joaquin Valley. Supervisor of Trinity County, a small county in northern California, want to sell their hospital, the only one in the entire county.

The selling of public hospitals to for-profit hospital chains is a particularly ominous trend. One must ask why these chains covet public (and voluntary, private) hospitals. Is it to serve the poor or is it to make a profit? Stories are surfacing about the alarming practices of private hospital chains when confronted with the poor who lack health insurances. Recently, an AMI San Diego hospital lost a wrongful death suit for turning away a small boy because his mother forgot her Medi-Cal card. The boy died shortly thereafter of viral meningitis. In Georgia, hospital data shows that Blacks and Medicaid recipients are not welcome at Hospital Corporation of America (HCA) owned hospitals in the state. HCA hospitals serve a disproportionately small number of Blacks and Medicaid recipients. In one Alabama County, Hospital Corporation of America promised to provide a certain amount of free care to County indigents if they were sold a hospital in the County. Of course, they refused to do so once the sale was made. A few months after the 1981 sale, the budget line item for free care was zero. There is no assurance that the private for-profit sector will provide care for the poor at rates the public sector can afford to pay. Once a public hospital is sold, the local government is at the chains' mercy---the chains can change what they want for indigent care.

Private, for profit chain hospitals are expensive. A recent study by Lewin and Associates show that per patient day costs of for profit hospitals are substantially higher than costs at comparable voluntary hospitals. Their drug costs, then administrative costs, and their ancillary services costs are higher. The sale of public hospitals can mean only one of two things--an increase in the cost of providing indigent health care or a decrease in the amount of care provided. Public hospitals do not belong to Supervisors or Mayors. Local officials only hold these institutions in trust. To sell these hospitals is a betrayal of that trust.

In many instances, public hospital closure is the final, inevitable act of the public hospital drama. Public hospitals, after years of neglect and cutbacks, reach a point where they are no longer salvagable. With few exceptions, almost every large urban public hospital in this country is in a precarious financial position. Grady Memorial in Atlanta, Charity Hospital in New Orleans, D.C. General in Washington D.C., Boston City Hospital, Cook County General, the entire New York City municipal hospital system and many others are operating with huge financial deficits. It is impossible to predict the number of public hospitals casualities in the coming years. Too many, surely, unless we can find a way to save these institutions.

IV. The Impact of Public Hospital Cutbacks and Closure

Public Hospitals are irreplacable. There loss has profound implications for the health of the community. This is especially true for maternal and child health care and communicable disease control.

Public hosptials and clinics are a major provider of obstetrical services for low-income women. In ten states, more than 30% of all babies born during 1980 were cared for during gestation in public health department clinics.

In California, poor women are increasingly dependent on county-funded services. Births at Ventura County General Hospital increased from a yearly rate of 761 in 1974 to 1,451 in 1978, due "primarily", according to one consultant's report, "to the reluctance of private physicians to care for low-income and high-risk obstetrical patients..." Los Angeles County-USC Medical Center alone performs over 11,000 deliveries a year; in Los Angeles County over 10% of all deliveries are performed at this one county hospital. In all, fifteen counties in California provide obstetrical services and 15% of all births in the state occure in county hospitals. Without these facilities, thousands of pregnant women would be unable to obtain prenatal, delivery and post-partum care.

Alarmingly, we are already beginning to see the impact of L.A. County budget cuts and the imposition of charges on the delivery of prenatal care for poor women in the County. Dr. Jim

Padbury, neonatalogist at Harbor General Hospital, reports that in December of 1980 there were 2000 prenatal care visits to 13 health clinics in the western part of the country. Because of County restrictions, by May 1981 there were only 1300 visits a month. Three of the thirteen clinics were closed in July. While statistics are not yet available on the impact of these closures and the further cutback in clinic services, it seems certain that fewer and fewer women will get prenatal care through the county system. Dr. Bradbury also reports that there was a minimum of 165% increase in the women delivering babies at Harbor in August and September of 1981 who had no prenatal care compared to the women who delivered babies during the hospital in August and September of 1980.

The moral and economic implications of this decline are obvious. Prenatal care is essential for the delivery of a live and health baby. Prematurity is the 6th leading cause of death in this country and is associated with half of all infant deaths. A women who has had no prenatal care is three times more likely to give birth to a premature infant than a women who has had that care. Lack of prenatal care also increases the likelihood of the birth of a physicially or mentally handicapped child. It cost on the average $79,400 to care for a premature newborn; nationally, yearly institutional costs for the severely mentally retarded averaged $13,000 in 1977. It is far less costly and far more humane to provide prenatal care to the poor.

Communicable disease control is another instance where the impact of county health service cuts will be felt immediately. T.B. rates increased by 30% in 1980 in Los Angeles County. While the County still provides free T.B. screening, T.B. is often first diagnosed by visits to county health clinics by persons who do not know they have T.B. With little ambulatory care provided and a $20 fee for all clinic visits, there is a strong possibility that next year's T.B. increases will make last year's 30% increase look like a minor outbreak.

IV. Solutions?

There are no easy solutions to the problems plaguing public hospitals. Provisions in the Omnibus Reconciliation Act permitting states, when setting Medicaid reimbursement rates, to take into consideration the indigent care provided by public hospitals will help. So will the new HMO provisions of the Act. But, these are not enough.

Without federal assistance, we will continue to lose public hospitals. Public hospitals need federal money and they need it now if they are to survive. The money from just one B-1 bomber would relieve the plight of the majority of these institutions. With the federal government gutting indigent health programs it will be difficult to legislate this aid. The demand must be made, regardlesss. Poor people and their advocates look to this important committee to continue to provide the leadership necessary to make federal aid possible.

It is ironic that the United States spends more on health care than any other nation on earth yet does not provide care for those most in need. Our health care system is extremely inefficient, wasteful and inflationary. Last year alone, despite the so-called voluntary cost-containment effort, hospital costs went up almost twenty percent. To deal with this waste, inefficiency and inflation, we can do one of two things: we can rationally look at the system and the causes of inefficiency and waste and respond accordingly, or we can indiscriminately cut services to those least able to protest these cuts---the poor. We seem to have chosen the second alternative.

We are not a cruel nation but it is an act of cruelty to deny pregnant women, poor children and the elderly health care. We are not an ignorant nation, but the failure to control the spread of communicable disease is an act borne out of ignorance. Nor are we inhumane, but to allow the destruction of public hospitals, upon which millions of poor people depend, is a callous and unreasonable omission in duty which will come back to haunt us.

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Please Reply to:

February 8, 1982

Congressman Charles B. Rangel
Committee on Ways and Means
1102 Longworth House Office Building
Washington, DC 20515

Dear Congressman Rangel:

In addition to my testimony of January 12, 1981 on public hospitals I would like to submit the following recent examples of private hospitals and physicians refusing to care for Medicaid recipients and the poor. I have also enclosed documentation for these "horror" stories.

Unfortunately, the following litany of "horror" stories are not isolated instances of a basically decent health care system; they are only the tip of an iceberg imbedded in the rock of private sector indifference, an iceberg which grows larger with each round of federal health cuts.

Alemeda County, Oakland, California: December 1981

Children's Hospital Medical Center of Oakland, California is planning two actions which will be disastrous for the poor children of the community. The hospital plans to:

(1) "close or severely curtail all of our various outpatient clinics, departments and centers". The hospital which treats more than 100,000 outpatients yearly says it is "forced" to take this action because about "seventy-five percent of the outpatients are in the Medi-Cal program or could otherwise be classified as indigent".

(2) "implement a strict credit policy for outpatients". Non-emergency care will be denied all children unless their parents make a cash deposit or they have Medi-Cal or other insurance coverage.

Alemeda County, California: January 1-July 15, 1981

A study was done of all records from Highland Hospital's emergency room from January 1 to July 15, 1981.

Highland is Alemeda County's public hospital. Study results demonstrate the degree to which "patient dumping" or the transferring of uninsured or Medicaid patients from private hospitals to public hospitals continues unabated:

(1) Of the 475 patients transferred, 76% came from Hill-Burton obligated hospitals.

(2) 43% of the transferred patients had no coverage, 36% were Medi-Cal or Medi-Cal pending and 12% had Medicare.

(3) Over half of the patients transferred were sick enough to be admitted to the hospital; 15 cases (3%) were immediately admitted to intensive care.

(4) In one instance, a 54 year old black male without insurance was transferred with a blood pressure of 220/110 (normal is 120/80). Upon reaching Highland, an x-ray revealed he had an expanding abdominal aortic aneurysm requiring immediate emergency surgery.

(5) In another case, a 21 year old female without insurance was transferred from a private hospital bleeding internally with a fractured pelvis, two fractured ankles, a fracture of the left arm, a fracture of the left femur, multiple lacerations of the face and a ruptured aorta (the largest blood vessel of the body).

Los Angeles, California: July 1980

In a series of articles on patient dumping in Los Angeles, two Independent Press Telegram reporters found that:

(1) A substantial number of patients who are hemorrhaging are being moved from private hospitals to county-operated institutions even before the extent of their bleeding is defined or the bleeding is fully brought under control.

(2) Many victims of accidents resulting in serious head injuries are moved, although little or no effort is made to assess the extent of their injuries or to determine if the ambulance ride to the county hospital will compound the injuries' effects.

(3) Many of these patients are moved even though they are in shock or in comas.

(4) Badly injured or seriously ill patients who should be admitted quickly to intensive care units are first kept waiting, often for four to 12 hours, in emergency rooms until arrangements are made to shunt them over to a county hospital.

The reporters detailed a few of the inappropriate transfers: a 23 year old pregnant accident victim who died because of an inappropriate transfer; a 25 year old man with multiple fractures, a lacerated kidney and a cut of the thoracic aorta; patients with "uncontrollable bleeding"; a 22 year old man shot in the chest who was not even given a blood transfusion at a private hospital before being transferred; a 30 year old man with a stab wound to the chest and uncontrollable bleeding; a 6 year old boy who lay unconscious at a private hospital for six hours before being transferred (he was not breathing when he arrived at the public hospital); a man with a fractured hip who was kept at a private hospital for eight hours before transfer and who suffered permanent pain and disability as a result.

Los Angeles, California: April 1980

According to a California Board of Medical Quality Assurance investigation a woman was received for emergency care at East Los Angeles Doctor's Hospital. She had a "ruptured ectopic pregnancy", was "actively bleeding,... in shock" and "barely responding to intravenous fluids and plasmanate". A surgeon arrived approximately an hour after the patient's arrival and obtained permission for surgery from her husband. The patient was prepared for surgery. As the patient was about to go into the operating room, the doctor learned she did not qualify for Medi-Cal and had no insurance. The doctor then "demanded $1000 in cash prior to performing the surgery." The family did not have the money and the doctor cancelled the surgery. Approximately four hours after her arrival in the emergency room, the patient was transferred to Los Angeles County-University of Southern California Medical Center where surgery was performed. She was "in critical condition at the time of transfer."

San Diego, California: February 1981

El Cajon Valley Hospital, a for-profit facility owned by American Medical International lost a $300,000 wrongful death suit. The hospital had turned away a small 4 year old boy because his mother had forgotten to bring his Medicaid card to the hospital. The boy died later of spinal meningitis.

San Diego, California: November 1981

El Cajon Hospital (see above incident) announced it planned to cut its intake of Medi-Cal funds from 20% of overall revenue to 5%.

San Diego, California: December 1981

Children's Hospital announced it would have to substantially reduce the $1 million worth of free care it had been providing the city's poor children.

San Jose, California: July 1981

On July 4, 1981 a pregnant woman was accidentally shot in the arm as she watched a fireworks display in San Jose, California according to an article in the San Jose Mercury. She was taken to the nearest hospital but was told she would have to go to the county facility because the hospital could find no orthopedist willing to remove the bullet. "They said that because I was on Medi-Cal, they couldn't find a surgeon that would treat me." The medical director of the area's Profession Standards Review Organization stated that "rejection of Medi-Cal or Medicaid recipients is not uncommon."

Georgia: February 1981

A Georgia Legal Service's analysis of health planning data shows that Hospital Corporation of America (HCA) owned hospitals provide little care to Blacks or Medicaid recipients. Also of the six HCA hospitals surveyed, five had no charity patients during the survey month.

The following tables document this conclusion.

TABLE 1

HCA HOSPITAL	COUNTY	% MEDICAID DISCHARGES	% IN COUNTY RECEIVING MEDICAID
Coliseum Park	Bibb	.02	10.1
Palmyra Park	Dougherty	5.5	11.2
Redmond Park	Floyd	2.9	6.4
West Paces Ferry	Fulton	2.0	11.1
Lanier Park	Hall	2.5	5.2
Worth County	Worth	17.0	11.3

TABLE 2

HCA HOSPITAL	% OF ITS FAIR SHARE OF MEDICAID PATIENTS SERVED
Coliseum Park	.2
Palmyra Park	49
Redmond Park	45
West Paces Ferry	18
Lanier Park	48
Worth County	150

TABLE 3

HCA HOSPITAL	% MINORITIES DISCHARGES	% MINORITIES IN COUNTY *
Coliseum Park	14.3	43.1
Palmyra Park	22.1	44.0
Redmond Park	7.1	13.3
West Paces Ferry	11.3	40.8
Lanier Park	1.1	10.1
Worth County	45.6	37.8

TABLE 4

HCA HOSPITAL	% OF ITS FAIR SHARE OF MINORITIES SERVED
Coliseum Park	33
Palmyra Park	50
Redmond Park	53
West Paces Ferry	28
Lanier Park	11
Worth County	121

Bibb County, Georgia: June 1981

A black man took his daughter to Coliseum Park Hospital in Bibb County, Georgia. She was in labor and her doctor, who had staff privileges at the hospital, told her to go to Coliseum Park (an HCA owned facility). After about an hour at the hospital, the admitting clerk found out that the laboring woman had neither private insurance or Medicaid coverage. It was six o'clock in the evening when the clerk told the father that he had to immediately bring in $1000 in cash or his daughter would be transferred to the public hospital. The father argued that he could not raise the money. The clerk then made a phone call to someone in the hospital who confirmed the decision -- no $1000, no care. At this point the patient's doctor arrived and insisted she remain at Coliseum Park Hospital. The clerk reluctantly agreed but told the father he must bring in $1000 the following day.

Central Georgia: February 1981

According to Linnis Cook of Georgia Legal Services, high-risk poor pregnant women in Central Georgia are forced to travel three hours to obtain delivery care at Talmadge Hospital in Augusta. The state will pay only $100 of the cost of an ambulance if one is needed. Private hospitals in the Central Georgia Counties (e.g. Pulaski and Laurens) will not accept poor high-risk women in labor as there is no state or county reimbursement system to pay for the care. A three hour ride during labor for high-risk pregnant women is extremely dangerous.

Chicago, Illinois: September 1981

A story in the Chicago Sun Times of September 20 recounts how private hospitals are lying to Cook County General in order to obtain transfers for their Medicaid patients. In one instance, Billings hospital asked to transfer a patient with blood pressure of 160/100 and a "strange" electrocardiogram. When the patient arrived at Cook County, the patient had a blood pressure of 270/150 and was vomiting blood. The patient died the next day.

Chicago, Illinois: January 1982

A coalition of 50 senior citizen's groups called Metro Seniors in Action conducted a survey of 11 Chicago Hill-Burton hospitals. They found that many do not post the proper public notices of the availability of Hill-Burton in emergency rooms and admissions offices, that hospital staff were often unaware of Hill-Burton and that some hospitals illegally meet their free care obligation by writing off bad debts, an illegal practice.

Mississippi and Virginia: January 1982

A series of articles in the Richmond Times-Dispatch on infant mortality in the south noted that:

(1) In the Mississippi Delta indigent women are "often forced to drive a couple of hours to the University

of Mississippi Medical Center in Jackson, the nearest hospital that welcomes those who cannot pay."

(2) Washington County in Virginia has only two obstetricians, neither of whom will accept poor, uninsured women. One doctor refused an indigent woman care unless she brought $50 in cash to every appointment. In the Tidewater region of Virginia, one local hospital requires a $1000 payment before delivery. In the Hampton area, only two private obstetricians are accepting new Medicaid patients. Virginia recently dropped a $1.4 million program that was paying for hospitalizations of indigent mothers with pregnancy complications and their babies.

The National Health Law Program was pleased to have the opportunity to testify at the public hospital hearing in Denver. Again, thank you for holding the hearing and your efforts on behalf of America's poor.

Sincerely,

Geraldine Dallek

Geraldine Dallek
Health Policy Analyst

GD/dm

Enclosures

Chairman RANGEL. Mr. Whitecrow.

STATEMENT OF JAKE L. WHITECROW, EXECUTIVE DIRECTOR, NATIONAL INDIAN HEALTH BOARD, INC., DENVER, COLO.

Mr. WHITECROW. Mr. Chairman, members of the House Ways and Means Committee and Subcommittee on Oversight and Investigations, I have a prepared testimony that I have submitted for the record.

Chairman RANGEL. Without objection.

Mr. WHITECROW. My name is Jake Whitecrow. I am the executive director of the National Indian Health Board. We are the principal advocacy agency to improve the conditions for American Indians and Alaska Natives throughout the United States.

The Alaska Native Health Board along with the various other 11 area health boards throughout the United States have combined and formed, then, the National Indian Health Board some 11 years ago.

This particular organization is designed to speak to those primary benefits that are provided through the various treaties and other legal obligations that have been incurred as a result of the Federal/Indian relationship that has been in existence since the Constitution of the United States came into being.

It is our responsibility to bring to the various Members of Congress and to the various Members of both the House and the Senate in regard to how these particular actions today that are being experienced by Indian people—our first Americans across the country—how they are being affected by the various budget cuts that have been proposed by the current Reagan administration.

What is happening throughout the United States, bringing about very severe and dire situations that are affecting our Indian people that are living in the very remote areas of the United States, you take some of our people who are living in the Alaska Arctic Circle and some of our people who are living in the Everglades of Florida, our people who have recently been recognized as federally-recognized tribes in the State of Maine and our people who are living in the deserts of Arizona and New Mexico, the people who are living in the plains of the North and South Dakota country and the people who are living in the Indian country in Oklahoma, as well as Utah and the southern portion of the State of Colorado, these people are all in existence as a result of many different Federal public policies that had been in effect down through the many years since the European first came to this New World.

To reiterate a little bit of history, I would like to go back and expressly bring to mind that the native American under the European concept of government has experienced some eight separate policies that they have endured. These policies being either official or unofficial policies of both the Congress and of the various States, beginning with isolation followed by extermination, annihilation, and then reservation. Those four policies that the Federal Government imposed upon American Indians had many, many dire circumstances and created the deaths of many of our people.

Some of our tribes in those periods of time experienced up to 50 percent loss of their populations just due to the various diseases that they endured as a result of lack of immunity in order to combat all of the new European diseases that were imposed upon them.

Following the reservation policy, we then began looking at a new process whereby the Government says, "Well, it is about time we assimilate these Indian people. Let's assimilate them and make them part of the melting pot of the citizenry of the United States. Let's begin taking a look at abrogating our treaties and going back upon our word."

What good is the word of a nation if that nation cannot stand up and fulfill and meet its allegations?

Therefore, we were faced with an assimilation policy. Following that policy, then we had Congress take a look at the American Indian and say, "Well, it's time we relocate them. Let's relocate them from the reservations and put them into the cities." So they initiated the relocation program and they hired many Federal employees to look after these people and they moved them from their local environs into the big cities and all of them ended up down mostly in the slum areas of the metropolitan areas.

Following that, then they said no allocations for the Indian to live in the urban metropolitan areas after the Federal Government put them there.

Therefore the Government is responsible for them, but the current Reagan administration is saying, "No, we don't have any responsibility for the Indian people that have been relocated." So in Mr. Reagan's policies he proposed complete abolishment. He also proposed, "Let's do away with the community health representative program. It is no longer effective. Let's do away with the preventive health programs. It's no longer effective. Let's provide only those programs whereby we can reimburse those people who provide the services. Let's do away with any kind of concept of preventive health programs which really would benefit the American people in total throughout the United States."

Had we been given the opportunity to implement those many policies and those sound practices that our medicine men practiced throughout our reservation areas, you would see a new approach to Western medicine, a meshing of the old time traditional medicine with the medicine today that just treats only crisis situations.

Following the relocation program to the cities, then we had Congress taking a look and saying, "Well, it's time we do terminate our entire relationship with our first Americans. It is time that they stand on their own feet."

Certainly, the Indian people realize that it is time for them to stand on their own feet. However, the Congress has provided many bureaucrats to oversee them and these bureaucrats have been providing their thumb over these people and providing some 2,200 more rules and regulations that these Indian people have to live and abide by daily than does any other citizen of the United States.

I know this because I served on the American Indian Policy Review Commission as a commissioner in 1975, through 1977. And we reviewed the entire Federal/Indian relationship. Only since the enactment of the self-determination policy, which replaced the termination policy of the Congress in 1954, that new policy enunciated by the Congress through Public Law 93-638 in 1975, creates a new direction that the Congress has pointed itself toward.

And we ask this particular committee, when you start making those determinations upon the budgets to realize that those budget obligations to the first Americans in the field of health and in the field of economic development are most important because we do have many resources. We have resources that will equal some 50 percent of the total energy resources of the United States.

And the Congress, through the Bureau of Indian Affairs and its agencies, are controlling the development of this. The Congress and its Indian Health Service is holding down the development of our Indian people. The Congress is failing to appropriate the necessary moneys through Public Law 94-437, the Indian Health Care Improvement Act, which would provide the necessary scholarship money for our Indian people to achieve professional status in the field of medicine.

I have submitted our proposed testimony to you and I am prepared to submit any additional horror stories because in our office we do receive those horror stories. I have heard testified this afternoon many testimonies that pertain to what the drastic budget cuts are going to do in the public health hospitals and what they are going to do in the private hospitals. And you can rest assured, with the budget cuts that we have experienced in the Indian Health Service, our Indian people, too, are going to be funneled and channeled through to those public health facilities and we will expect them to be treated.

It is an obligation of the United States of America to fulfill sacred words and solemn treaties. Without that fulfillment, then the word of the United States leaves a lot to be desired.

Thank you for the opportunity of presenting this testimony. And our office will stand by to assist this committee in any way possible.

[The prepared statement follows:]

NATIONAL INDIAN HEALTH BOARD, INC.
"The 1980's: A Decade of Indian Health Initiatives"

MEMORANDUM

TO: House Ways and Means Committee

FROM: Jake L. Whitecrow, Executive Director

DATE: January 12, 1982

SUBJECT: Testimony to U.S. House of Representatives, Committee on Ways and Means, Sub-Committee on Oversite and Investigations

Mr. Chairman and Members of Congress serving on the House of Representatives, Committee on Ways and Means, Sub-Committee on Oversite and Investigations, it is an honor to appear before you and present testimony concerning the affects the Federal Budget Cuts have upon American Indians and Alaska Native Health Services.

My name is Jake Whitecrow and I am the Executive Director for the National Indian Health Board. We maintain our Headquarter's office in Denver, Colorado and have twelve Area offices throughout the United States. Our Area offices represent the Indian tribes and Alaska Native Villages. We are the principal advocate agency to maintain and improve health conditions and services for our First Americans. We also function as the primary Advisory Board to the Director, Indian Health Service.

The 1982 Fiscal Year Budget for the Indian Health Service reflects severe cuts in services, facilities, and manpower available to meet the needs of our First Americans. I am attaching an enclosure which expresses the History of the 1982 FY budget process. In referring to this attachment, you can compare 1981 and 1982 budget line items for the Indian Health Service.

The referred line items reflect severe cuts in the Community Health Representative (CHR) Project. This program is the primary program utilized by the tribes to deliver and reach their people in the most isolated of the isolated and remote locations on Reservations and in the far outreaches. The result will be less medical attention available to our people. This CHR program provides the home visits to the elderly as well as filling needed positions in the IHS clinics and those tribally operated facilities.

We have been informed by many tribes of how they are being individually affected. I am enclosing some of their statements as attachments to this testimony. These letters reflect the individual situations in their areas.

The major problems in the IHS budget is that there is a decrease in the overall services budget between FY '81 and FY '82. The number of Federal personnel on the payroll must be administered. They have annual mandatory step increases and numerous other fringe benefits that must be extracted from this budget. There is no provision for this. There is no consideration for the affects of inflation and therefore, their will be greatly reduced money for medicines, supplies, and equipment replacement or purchases.

The Tribal and Indian organization contractors are being told by IHS personnel that they must be prepared to experience drastic cuts in their operations. Therefore, we have been informed that some Tribes have been required to lay off 75% of their Health staff. We are expecting unemployment on some reservations to hit a high of 80% of the population.

Provisions must be made by the Congress to limit the amount of reductions in the Budgets that allow the Administration to impose these kinds of decreases to Tribal involvement.

Contrary to what many people believe all Indians are not Rich. Not all of our Tribes have Energy Resources. Only a few of our lucky ones do.

The vast majority need assistance and they have only the Federal Government to look too. The programs and projects that you provide have only been available for a short time. The Congress has begun to line up to its legal obligations and moral committments its agreed to in the many Treaties. Don't drop the ball when we have just begun to see a small light at the end zone.

The 93rd Congress started with a Self-Determination Policy. We are asking that you fulfill that committment and don't turn your back on a project that has the opportunity to make many contributions to the future.

If you put the funding back into the Indian Health Service and the Economic Development for Reservations and Indian Country, we will see a bright future for our First Americans. Congress can then take the credit for providing the initial impetus to create those jobs and professional development that this funding will provide.

If the trend of reduced monies in Indian funded projects is continued, you may see an end to Indian Tribes and Organizations as we now know them.

Thank you for the opportunity for appearing here today.

History of Administration and Congressional Action
Indian Health Service Budget
Fiscal Year 1982
(In thousands)

	FY 1981 Final Pos.	FY 1981 Budget Amount[1]	FY 1982 Reagan Pos.	FY 1982 (March)[2] Amount	FY 1982 Reagan Pos.	FY 1982 Revised Amount	FY 1982 House Pos.	FY 1982 House Allowance Amount	FY 1982 Senate Pos.	FY 1982 Senate Allowance Amount	FY 1982 Conf. Pos.	FY 1982 Conf. Allowance Amount	FY 1982 Approved Pos.	FY 1982 Approved Budget Amount
IHS HEALTH SERVICES														
Clinical Services:														
Hospitals & Hlth Clinics	7,122	$310,040	7,122	$318,146	7,122	$307,367	7,221	$310,146[3]	7,221	$318,146[4]	7,221	$318,146[4]	7,221	$305,420
Dental	653	17,692	653	18,129	653	17,692	676	18,629	676	18,629	676	18,629	676	17,884
Mental Health	285	7,513	285	6,000	285	5,731	285	7,800	285	6,000	285	7,800	285	7,488
Alcoholism	-	15,237	-	16,969	-	15,955	-	16,969	-	16,969	-	16,969	-	16,290
Maintenance & Repair	-	8,611	-	8,611	-	8,611	-	8,611	-	8,611	-	8,611	-	8,267
Contract Care	-	107,465	-	115,028	-	107,465	-	115,028	-	115,028	-	115,028	-	110,427
Equity Health Care	-	7,856	-	16,054	-	12,754	-	16,054	-	16,054[5]	-	16,054[5]	-	15,412
Total, Clinical Services	8,060	474,414	8,060	498,937	8,060	475,575	8,182	493,237	8,182	499,437	8,182	501,237	8,182	481,188
Preventive Health:														
Sanitation	587	15,088	587	14,177	450	11,447	587	14,677	587	14,677	587	14,677	587	14,089
Public Health Nursing	317	8,006	317	8,301	317	8,006	317	8,301	317	8,301	317	8,301	317	7,969
Health Education	102	2,149	102	2,285	45	1,000	102	2,285	102	2,285	102	2,285	102	2,194
CHR's	9	36,304	9	39,083	-	-	9	39,083	9	24,583	9	30,000	9	28,800
Total, Preventive Health	1,015	61,547	1,015	63,846	812	20,453	1,015	64,346	1,015	49,846	1,015	55,263	1,015	53,052
Urban	-	8,900	-	4,450	-	-	-	9,790	-	-	-	8,500	-	8,160
Indian Health Manpower	-	5,808	-	3,792	-	2,792	-	7,317	-	3,992	-	6,000	-	5,760
Tribal Management	-	3,029	-	2,744	-	2,744	-	2,744	-	2,744	-	2,744	-	2,634
Program Management	1,622	53,011	1,622	53,050	1,622	50,037	1,622	52,050	1,622	50,886	1,622	50,886	1,622	48,851
Total, IHS Health Services	10,697	$606,709	10,697	$626,819	10,494	$551,601	10,819	$629,484	10,819	$606,905	10,819	$624,630	10,819	$599,645
IHS CONSTRUCTION														
Hospitals, New & Replacement		25,693		7,900		6,952		7,900		9,928		9,928		9,531
Modernization & Repair		3,300		200		176		200		200		200		192
Outpatient Facilities		4,456		-		-		10,014		10,014		10,014		9,613
Sanitation		50,240		-		-		28,625		26,125		28,625		27,480
Personnel Quarters		780		-		-		-		350		350		336
Total, IHS Construction		$ 84,469		$ 8,100		$ 7,128		$ 46,739		$ 46,617		$ 49,117		$ 47,152
TOTAL, IHS Budget		$691,178		$634,919		$565,857		$676,223		$653,522		$673,747		$646,797

1/ Includes FY 1981 Pay Act
2/ Excludes FY 1982 Pay Act of $13,424
3/ Reflects - $15 million for Medicare/Medicaid Reduction
4/ Reflects - $5 million for Medicare/Medicaid Reduction
5/ Includes $2 million redistribution of FY 1981 Base

Potawatomi INDIANS
of OKLAHOMA
ROUTE 5 BOX 151 SHAWNEE, OKLAHOMA 74801
PHONE 405 275-3121

BILLY JIM BURCH
TRIBAL CHAIRMAN

JOHN SCHOEMANN
TRIBAL ADMINISTRATOR

December 10, 1981

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DEC 14 1981
NATIONAL INDIAN
HEALTH BOARD

National Indian Health Board, Inc.
ATTN: JAKE L. WHITECROW
1602 South Parker Road
Suite 200
Denver, Colorado 80231

Dear Mr. Whitecrow:

Pursuant to your correspondence requesting information regarding the impact of reduced financial assistance and financial deferment upon the Citizen Band Potawatomi, the following data is submitted for your review and use.

BIA GRANTS AND CONTRACTS
FY81

NAME	LENGTH	AMOUNT
Indian Action Program	12 months	$ 86,560.38
Housing Improvement Program	12 months	$130,602.56
Self-Determination Grant (93-638)	12 months	$ 87,600.00
Youth-Work-Learn	1.75 months	$ 5,722.42
Commercial Enterprise Development	4 months	$ 9,800.00
Commercial Enterprise Development	2.25 months	$ 5,000.00
Agri-Extension Program	4 months	$ 5,541.50
		$330,826.86

BIA GRANTS & CONTRACTS - ORIGINAL AMOUNTS APPLIED FOR IN FY82

Indian Action Program	12 months	$ 75,300.00
Housing Improvement Program	12 months	$109,549.46
Self-Determination Grant (93-638)	12 months	$ 94,963.00
		$279,812.46

FY82 BIA GRANTS & CONTRACTS - ACTUAL AWARDS

Indian Action Program 2.5 months $ 18,825.00
** Due to Continuing Resolutions, the actual usable amount is 21% of 18,825 or $3,953.25 through 12-15-81.

Housing Improvement Program 2.5 months $ 68,000.00
** Due to Continuing Resolutions, the actual usable amount is 21% of 68,000 or $14,280.00 through 12-15-81.

Self-Determination Grant	2.5 months	$ 52,230.00
** Due to Continuing Resolutions, the actual usable amount is 21% of 52,230 or $10,968.30 through 12-15-81.		
		$139,055.00

IHS GRANTS & CONTRACTS FY81

Community Health Representatives	11 months	$141,284.00
Health Planning	10 months	$ 45,792.00
		$187,076.00

IHS GRANTS & CONTRACTS - ORIGINAL AMOUNTS APPLIED FOR FY82

Community Health Representatives	12 months	$158,627.00
Health Planning Grant	12 months	*$ 94,449.75
*Amount reduced by IHS to $10,419.00		$253,076.75

IHS GRANTS & CONTRACTS - ACTUAL AWARDS

Community Health Representatives	1.75 months	$ 20,072.00
Health Management (Planning)	--	$ -0-
		$ 20,072.00

TOTALS

BIA FY81	$330,826.86
IHS FY81	$187,076.00
	$517,902.86
BIA FY82 APPLIED FOR AMOUNTS	$279,812.46
IHS FY82 APPLIED FOR AMOUNTS	$253,076.75
	$532,889.21
BIA AMOUNTS AWARDED FY82	$139,055.00
IHS AMOUNTS AWARDED FY82	$ 20,072.00
	$159,127.00
BIA FY82 ACTUAL USABLE FUNDS	$ 29,201.55
IHS FY82 ACTUAL USABLE FUNDS	$ 20,072.00
	$ 49,273.55

As may be easily seen, the Tribe's operations in the above areas have been reduced by some $483,615.00 from original FY82 amounts, and by some $468,629.31 from FY81 funding levels.

All totaled, some 54 jobs have been lost as a result of the loss of federal financial assistance or deferral of such assistance.

The greatest impact has been in reduced housing, health, and economic development services to the Indian community. Indians are especially harmed in health and housing service areas. Mr. Reagan desires that Tribes achieve the same status as states, yet forgets that Tribes, as a general rule, have no tax base with which to fill the gap left by reduced federal aid.

Another concern of this Tribe, and many others, is the allocation of funds once they are received by a given agency.

For example, during the first round of budget cuts, the BIA's overall budget was reduced by $75,961,000.00. The BIA chose to reduce Indian Programs by $60,112,000.00. Indian Programs absorbed over 79% of the entire BIA budget cut!

During this same period, IHS's total estimated budget increased by $20,504,000.00, yet Indian Programs such as Mental Health, Hospital and Health Clinics, Sanitation, Urban Health, Health Manpower, Tribal Health Management, Health Program Management, all programs providing direct services to Indians, decreased by $13,537,000.00!

Perhaps some concern should be given by groups such as yours to equality of funding WITHIN A GIVEN AGENCY; for if this trend continues, Indian Tribes and Indian Organizations as we now know them will be destroyed.

Your organization is performing a commendable service to the Indian people and we encourage your efforts.

Should we be able to provide additional information, please advise.

Sincerely,

Billy J. Burch
Tribal Chairman
Citizen Band Potawatomi
  Indians of Oklahoma

BJB/DRH/rf

K
I
C

Ketchikan Indian Corporation
(IRA Council)
P.O. BOX 6855
429 DEERMOUNT AVENUE
Ketchikan, Alaska 99901

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NATIONAL INDIAN
HEALTH BOARD

BOARD OF DIRECTORS
(IRA Council)

MARY E. JONES
President

WILLIAM C. THOMAS
Vice-President

DOLLY JENSEN
Secretary

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EVELYN COLLINS
Councilwoman

ARLENE MAHAN JONES
Councilwoman

ALFRED JACKSON
Councilman

JAKE LAUTH
Councilman

EDWARD K. THOMAS
Executive Director

January 6, 1981

Jake L. Whitecrow, Executive Director
National Indian Health Board Inc.
1602 So. Parker Road, Suite 200
Denver, Colorado 80231

Dear Mr. Whitecrow:

Ketchikan Indian Corporation has contracted with Indian Health Service to administer positions at the Alaska Native Health Clinic in Ketchikan through P.L. 93-638. The original proposal called for administration of seven (7) positions. However, because of Federal Cuts two of these positions were lapsed. They were positions which we feel are necessary to the delivery of good health care to the Native people. The positions are accounting technician and receptionist. The jobs are being done by existing personnel and volunteers and this works a hardship on the Native patients as well as the staff.

In addition, the clinic has no funds for a custodial worker or deputy pharmacist. A clinical nurse position was lapsed also. Travel and pharmaceutical funds were reduced.

Overall, our Native population will bear a much larger share of the Federal Government's cuts than the percentages published.

It appears that the Indian Health Service administration avoids cuts in administration by passing the cuts on to the tribes who are responsible for service delivery, thus, causing the cuts to be much larger at the service delivery level.

Sincerely,

Joyce M. Beck
Health Planner

JMB/klf

cc: Ketchikan Native Health Board

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NATIONAL INDIAN
HEALTH BOARD

[illegible] [illegible] BY THE DELEGATION OF MS. JESSE JAMES, [illegible] [illegible] TO THE NATIONAL INDIAN HEALTH BOARD TO THE SENATE SELECT COMMITTEE ON INDIAN AFFAIRS:

"Effects of Administration Budget cutbacks as felt by the Keweenaw Bay Indian Community at the L'Anse Indian Reservation in the Upper Peninsula of Michigan."

In 1854, a treaty between the Chippewas of Lake Superior and the United States government was ratified granting reservation lands, reserving lands in the western Upper Peninsula of Michigan located in Baraga, Ontonagon and Gogebic Counties, withe the majority of these lands being located in Baraga County, for Indian use.

L'Anse Indian Reservation lands consist of 58,880 acres, the acreage has been reduced to 13,765 acres today, with 5,641 acres owned by the Tribe in common, and 8,124 acres individually owned. The land is approximately 91% forest land and this is considered a major asset of the tribe. The forest lands consist mainly of norther hardwoods, but does include mixed conifers. As previously noted much of the land was previously alloted to individual tribal members. The timber on alloted lands was cut in the period following the Civil War, when the Upper Peninsula of Michigan was the center of the logging industry in the United States and the Jack Pine was King. In the first decade of this century the pine, cedar and most of the hardwood was cut. Forest fires caused massive losses to the area.

The Keweenaw Bay Indian Community is situated in one of the most dense and rugged forestry areas of Michigan. Baraga County ranks second to neighboring Marquette County in available commercial fores acreage at the present time. The presence of the strong forest industry in Baraga County allows for potential employment and manufacture of diversified forest products. Reservation forest lands are in a tranistional stage in an on-going effort through timber stand improvement (TSI) to return to a hardwood cover type. In 1964 a forest management inventory was completed with a ten

ten year management plan prepared. The plan was updated in 1977. Northern hardwood covered approximately 50 percent of the total acreage with aspen being the only major non-hardwood species. There were a number of sawmill operations using primary type woods, with the Celotex Corporation being the largest user.

The Keweenaw Bay Indian Community has use of 4,016.5 acres of Farm Security Administration (FSA) lands; commonly known as submarginal land. Through Public Law 94-114, October 17, 1975, the title to the FSA lands was transferred to the tribe. This report will try to emphasize the development and utilization of natural resources.

You may be aware that the entire Upper Peninsula of Michigan is considered to be a year round haven for sportsmen and receationists. Some of the activities available here include the spring runs of rainbow trout, summer time activities involving fishing and other water activities, camping, hiking, sporting events and various festivals, fall color tours, hunting of deer, bear and small game and birds and a winter wonderland of activities including; snowmobiling, skiing, ice fishing, hockey and other winter sports. The Keweenaw Bay Indian Community has two nationally known fishing streams located within reservation boundaries. Keweenaw Bay is one of the best known lake trout fishing areas of Lake Superior. The waters of Keweenaw Bay include a wide variety of fish such as, rainbow trout, German Brown trout, Coho Salmon, Chinook Salmon, perch, bass, pike, Brook trout, bulegills and Whitefish to name a few. The area is characterized by extreme variations in temperature. The long cold winter have an effect on the employment in the area.

The linkage to commercial, industrial and cultural centers has been provided by the junction of a major U. S. Highway and a major state highway, considered to be a asset to the community, these highways alwo provide access to the L'Anse

Reservation area as a year long recreational area, connecting us with the large urban areas of the Midwest. The nearest commercial airline serving the reservatin area is 40 miles distant at the Houghton County Memorial Airport, while the Marquette Airport is some 60 miles to the east of the reservation. Regular daily airline service is provided by Republic Airlines, and a small Simmons Airline connects the district with the rest of the United States. The Baraga County area is served four (4) times daily by Greyhound Bus Lines, as well as the Soo Line Railroad. Keweenaw Bay Indian Community students are served by two public schools, L'Anse Township SChools and Baraga Area Schools, L'Anse-Baraga Community Schools, Sacred Heart Catholic Elementary, Headstart and the Tribally operated day-care center, with community college courses available at the Tribal Center trhough Tribally operated Ojibwa Community College and Learning Center. Several people are involved in Continuing Education Courses through Ferris State College, Big Rapids, Michigan.

In 1970, Baraga County, as was much of the country in the midst of an economic crisis, we were in the heart of a depressed area, to say the least. The Keweenaw Bay Indian Community Tribal Council has been in existence since the 1934 Indian Reorganization Act. The council made up of twelve elected officials had made little progress economically up until the early 1970's, it was at this time that the federal government took a new look at programs affecting Indian and with the enactment of the Indian Education Act of 1972, the Self Determination and Education Assistance ACt and later the Indian Health Care Improvement Act, along with programs designed to serve Indian people in the U. S. Office of Economic Opportunity and the Department of Labor programs that things began to move around here. Contrary to public belief, the programs just didn't happen, many of the programs were funded on a competitive basis, the L'Anse Indian Reservation competed with other Indian tribes and organizations across the country for the funds that wer to eventually literally pur into the reservation. Very few people stop to realize the heavy impact which the Keweenaw Bay TRibal Council has had in improving the economic conditions of Baraga County, Michigan in the last 10 years. Among the most notable achievements of the Keweenaw Bay Tribal Council have been the following: (SINCE 1970)

- Purchase of the former Capuchin Friary-Old St. Joseph Orphanage for $1.00.
- Establishment of a Comprehensive Health Service Clinic (MODEL) at the Tribal Center, employing a full-time doctor, registered nurse, a full-time dentist, WIC Program, Community Health Service, Prescritions & many other health related activities.
- Indian Action Team programs provided training to enable the Tribe to rain their own people in the building trades. These people worked on home winterizing, construction of home additions and basements and many went on to work on local HUD Housing.
- New Day Alcohol Treatment and Aftercare facility became a reality. Serving the whole state of Michigan, both Indian and non-Indians alike, creating a new awareness that help was indeed available to those addicted to the disease of Alcoholism.
- Establishment of a Young Adult Conservation Corps (YACC) Employing young adults of Baraga County and surrounding areas in needed Conservation areas. This program employed well over 600 people, teaching job skills, safety, for most it was the first job ever held. Many agencies in the county received benefits in building renovation and conservation projects, plus the camp oversaw the operation of ten (10) satelite operations with headquarters here, at the Tribal Center, serving reservation areas in other Upper Peninsula of Michigan communities as well as neighboring Northern Wisconsin.
- The Ojibwa Senior Citizen Center became a reality, allowing for a base of operation for our many older Americans, a model Title VI Nutrition program is in full scale operation providing daily hot meals to more than 50 people at the center, delivering hot meals to those confined to their homes.

- The operation of Michigan Inter Tribal Education (MITE) at the Tribal Center through a contract with the Bureau of Indian Affairs has allowed educational services to be increased to tribal members to continue their educational endeavors beyond high school. The drop-out rate said by some to be 86% in 1970 among our Indian students has been reduced to practically zero. Many of our local graduates go on to some form of higher education.

- The establishment of older workers employment programs, establishment of the following departments: Tribal Police, Tribal Conseervation, Legal Services, Educational, Tribal Construction all have become viable programs of the Keweenaw Bay Indian Community, through the efforts of the Tribal Council.

Many problems still face the Keweenaw Bay Tribal Council in the very near future, but many reservations face those same type prospects in the next year because of budget cuts. At this point in time it is impossible to predict how much Indian Tribes are going to suffer as a direct result of those proposed budget cuts. It is difficult to determine how much federal aid will be lost in this area. The Bureau of Indian Affairs, which is supposed to look after Indian interest is recommending the cuts to meet with the Administrations budget goals. There are at least five other federal agencies that have programs to aid Indians, what is certain is that all of those agencies are slated for cuts. The cuts in development and cuts in the Comprehensive Education and Training Act (CETA) could almost double the unemployment rate. Local Michigan Employment Security Commission (MESC) Job Service officials indicate that the unemployment rate locally is well over 17.5" at the present time, this does not reflect those whose benefits, including supplemenatary benefits have run out. The national unemployment on Indian Reservations is at the present time 37%, and is expected to reach in excess of 60% according to figures from the National Tribal Chairmans Association. It is the feeling locally the the heart of the budget battle strikes at the heart of tribal sovereignity and the protection of treaty rights. If many of these critical health and social programs are defunded Indian people will again be forced to turn to the state for essential services, thus undermining the very basis the tribe as a full and viable unit of government capable of serving its own people. The termination of many of the programs will force the Keweenaw Bay Tribal Council to pull dollars away from economic investments and job development in order to preserve essential services to tribal members of the Keweenaw Bay Indian Community, thus slowing down economic development on the L'Anse Indian Reservation.

As we enter this new year of 1982 we ask you to consider the impact the Tribe has had on Baraga County, Michigan in the last decade. The Tribal Council asks you, to take a look at the past, what were you doing in 1970? What are you doing today? There is a need for tribal people to pull together, to make the most of the opportunity to provide the best possible lifestyle for our people.

There are at the present time 142 people working for the tribe, before the end of 1981 this number will drastically decrease with the ending of the Young Adult Conservation Corps (YACC). In Education a new 35% cut means that we are going to have to start terminating people in January 1982. The Indian Action Team has been cut 100%, this means we are going to have to lay off our young people involved in our training program. Adult Education has been cut completely. This program has helped adults in areas that have been very beneficial to the tribe. Road Programs through the Bureau of Indian Affairs have been eliminated. In the area of CETA--this program has been cut in its entirity. This almost assures us of 100% unemployment. The people with any kind of training will have to leave here, because there is no base to promote a n economically healthy community. Those people without training are coming back to the L'Anse Reservation in large numbers placing an addional burden on avialable services.

In the area of health, our Health Careers Recruitment program from the Indian Health Care Improvement Act (437) has been totally eliminated. Cut backs to Contract Medical Services contract is and additional drastically cut. We anticipate cutbacks in the Community Health Representative Budget, we have to await the final budget of the administration to realize the full extent of the program cutbacks.

The Michigan Inter Tribal Education Assoicaition (MITE) Higher Education Scholarship program has been cut in half, this program is on a 638 contract from the Bureau of Indian Affairs and is supplemental in nature to the financial assistance received by our students after all other sources have been used.

A strong Tribal Council is need today to meet the demads facing Indian people today, we have no senator or congressman to represent us , there is much to be accomplished in program areas affecting the Keweenaw Bay Indian Community today, we need your support.

Thank you.

Chairman **Rangel**. Thanks for your eloquent testimony.

Most of your concerns concern us as Members of Congress, but fall outside the direct jurisdiction of this committee, and so I may be asking you for some additional information because I think that will come under the Commerce Committee. But I would still want, as a Member of Congress, to do all that I could to make certain that these obligations are met.

Mr. **Whitecrow**. Thank you, sir.

Chairman **Rangel**. Mr. Kleyn is here for Sister Mary Andrew.

STATEMENT OF SISTER MARY ANDREW, PRESIDENT, ST. JOSEPH HOSPITAL, DENVER, COLO., PRESENTED BY HANS KLEYN

Mr. **Kleyn**. Thank you, Congressman Rangel.

I am Hans Kleyn, vice president, finance, St. Joseph Hospital, and I am here on behalf of Sister Mary Andrew, who is the president of St. Joseph Hospital, which is a 550-bed teaching hospital in the innercity of Denver.

We also happen to be the first private hospital in the State of Colorado, and have celebrated our 108th birthday this year.

St. Joseph Hospital is also a member of a chain of eight hospitals that is owned and operated by a religious community, the Sisters of Charity of Leavenworth, Kans.

As I say, I represent or speak on behalf of Sister Mary Andrew, and I would like to read her testimony that also has already been delivered to the committee, although, since I feel strongly about some of the issues, I hope that I will be permitted to ad lib and enlarge on the testimony.

Chairman **Rangel**. Well, since we have the testimony, if it is more comfortable for you, we will put the document in the record for the good sister and then you could just speak to those things that you have such strong concerns about.

Mr. **Kleyn**. Yes, although the testimony is quite brief and we would like it to address three issues that are of specific concern to us.

First of all is the matter of the nursing differential for medicare patients. When the Congress adopted the medicare legislation and as this was implemented, medicare used to allow hospitals a 2-percent payment on total costs in lieu of specific recognition for other costs.

In 1968, medicare abolished the 2-percent payment on total costs and substituted an 8½-percent allowance on nursing costs only. This in itself already meant a decrease in payment.

I should like to stress the fact that this previously allowed 8½ percent nursing differential, when you actually came down to the fact, it did not represent an 8½-percent nursing differential because once you had determined medicare allowable nursing cost over which the 8½ percent could be calculated, the Health Care Finance Administration in its creative cost reporting formulas also increased the denominator by which you divided that by 8½ percent. So that by the time you got all through, the 8½ percent actually, at least in our case at St. Joseph Hospital, resulted in an additional nursing differential payment of approximately 2 percent of cash in bank.

And I think that we might all agree that cash in bank is the important factor when you come to talk about the 8½ nursing differential.

In 1981, the nursing differential was decreased from 8½ to 5. In 1982, medicare, because of budget problems, wishes to completely eliminate this differential. We feel that this is not just because, first of all, medicare patients do require more nursing care. They require custodial care, as well as acute care when hospitalized.

The hospitals do try to monitor their care so that the level of care is appropriate. We all realize that as our aged population increases there will be increased medicare needs.

Second, hospitals do want to take care of all patients equally. We do not differentiate between levels of care. For years we have lived with inadequate reimbursement due to the contractual agreements with medicare and medicaid and we have included these losses in the rates paid by the nonmedicare and nonmedicaid patient population.

And hospitals are then criticized for the high cost of health care.

The General Accounting Office, as we understand it, is to do a study by February 1982, to determine whether there is really any difference in costs for nursing medicare patients over against other patients.

A study done by the Health Care Financing Administration concludes that there is no evidence to justify this nursing differential. Yet, on the other hand, a second study that was conducted on behalf of the Health Care Financing Administration by Lewin & Associates of Washington, D.C., showed that medicare patients require 10 to 14 percent more nursing care today than all other patients.

We are concerned that the February study to be done by the General Accounting Office will be conducted hurriedly, will not use proper evaluation methods and will not be objective.

We also are concerned that if an objective study was done and it was documented that the medicare patient, indeed, require 10 to 14 percent more nursing care, we wonder what the Health Care Administration would then propose. Would they adopt, then, a 10- to 14-percent nursing differential? In other words, the elimination of the nursing differential for medicare patients will simply result in cost shifting from the public to the private sector and will increase hospital costs per day.

Reduced medicare reimbursement simply results in greater medicare contractual losses, losses that are simply recycled into the rate structure that are then paid for by all nonmedicare and nonmedicaid patients. So you are merely dealing with a cost shifting from the public to the private sector. And this has been going on for years.

Our second concern deals with funded depreciation. Ever since the enactment of medicare legislation, hospitals had to be encouraged to fund depreciation. The importance of funding depreciation was given impetus through a Federal Government incentive whereby the investment income from funded depreciation was not offset against interest expense on long-term debt.

As a result thereof, hospitals had an opportunity to build some capital for the replacement of outmoded facilities and equipment, as well as mitigate in part the ravages of inflation.

It is now proposed again, although last year it was proposed and defeated in the Congress, but it is now again proposed by the Health Care Financing Administration through regulation rather than through legislation to eliminate the funded depreciation investment income and in the future will need to be offset against interest expense on long-term debt. Unquestionably this will help the Federal budget in its attempt to reduce health care expenditures.

However, it will only increase hospital costs once again and therefore transfer more costs from medicare to the nonmedicare patient population.

The administration speaks enthusiastically about introducing competition among hospitals as a means to control hospital costs. Attached to our testimony is an exhibit which documents and demonstrates what happens to hospital prices at various levels of medicare and medicaid participation. This study clearly documents that a hospital with an 80-percent medicare and medicaid patient load must increase prices by 80 percent compared with the hospital which has no medicare or medicaid patient population in order to keep its financial viability to provide services.

It is ironic that the Congress is presently asked to enact proposals that are counterproductive to the very competition it proclaims.

I should like also to address one other point about increased hospital costs. The Congress has passed legislation which the President has signed as I understand it, last Friday, whereby sick pay now becomes subject to FICA taxes which previously was excluded from FICA taxes. Undoubtedly this legislation will improve the viability of the social security system but it should not be forgotten that there is an offset because since hospitals being very labor-intensive previously did not have to pay FICA taxes on sick time now will have to pay FICA taxes on sick time. As a result thereof, in our case at St. Joseph Hospital, it will increase the cost per patient day by 70 cents. And since our patients stay approximately 6.3 days in the hospital, this will add approximately $4.50 to each patient bill.

And yet both the public as well as the Federal Government is very concerned about increased hospital costs. Much of it is directly the result of legislation.

Finally, Sister Mary Andrew would like to address the matter of the medically indigent. Sister Mary Andrew did attach a copy of the Denver Medical Society statement concerning medical indigence. We are all trying to assess the magnitude of the problem and solutions for Denver and Colorado. We do not have complete testimony for you at this time but will send you our thoughts.

Then, finally, much testimony has been heard this afternoon about the burden of the public hospitals in relationship to charity work. Some references have been that the private sector is not carrying its load or does not discharge its appropriate responsibility in the care of the poor. I would like to add to Sister Mary Andrew's testimony that as a member of the private sector, we do not feel that that is entirely a correct picture that is being painted.

St. Joseph Hospital is a 550-bed private voluntary nonprofit institution. Each year our board specifically allocates certain amounts of money which this year amounts to $1 million for the care of the poor and the medical indigent. It would be easy to increase such allocations to $2 to $3 million, $4 million but let there be no mistake about it that such increases would merely be recycled through the rate structure and become a burden upon the community. And since increases in hospital costs are measured on the basis of prices charged, as you increase the amount of charity care to help the medical indigent patient population, you simply recycle it through your rate structure and it becomes the burden and responsibility then of the total community.

Chairman **Rangel**. Could you go through that a little more slowly? What is your job at the St. Joseph?

Mr. **Kleyn**. Vice president of finance.

Chairman **Rangel**. What was that that you just said? That as you increase the charitable contribution, you merely recycle what?

Mr. **Kleyn**. We merely recycle the $1 million that we, by budgetary allocation, provide for the medical indigent and the poor to provide free health care for them. Somebody must foot that particular allocation. How is it footed? How is it funded? It is funded through the rate structure of the hospital, through the prices that it charges to all other patients.

Chairman **Rangel**. Oh, you mean you spread the cost of the poor patients to the nonpoor patients?

Mr. **Kleyn**. To the paying patients. So as you increase the $1 million to $2 million, you can do so.

Chairman **Rangel**. I just get a little confused when it gets to religious institutions. In other words, you do check or feel that you have to check the ability of the patient to pay and then you decide, based on what the trustees have made available, as to how many poor patients you can take in and to bring some balance so that those patients that go into St. Joseph's that can pay their own way, that they don't carry the weight of the poor?

Mr. **Kleyn**. If they pay their proportionate share.

Chairman **Rangel**. Proportionate share, but the trustees and the executives have to bring about that balance?

Mr. **Kleyn**. Pay their proportionate share of the poor. Plus what we are able to raise through philanthropies, that is correct.

Chairman **Rangel**. OK. I know that we are better off having the churches involved in providing this care. As a matter of fact, the churches were the first to provide care when the Government did not do it. I just don't have the sophistication at this point to feel comfortable in seeing clergy people make the decision as to a person's ability to pay before admission. I assume the way this administration is going I will reach that, but it is just very, very difficult for me, you know, to see how that determination is made.

I can see how it is made in for-profit hospital and for elective type of surgery and things of that nature, but I don't mean to question you because you follow policy and this is the policy that has been set out.

Mr. **Kleyn**. But even if the $1 million or $2 million, whatever you allocate, somebody must fund it. Somebody must somewhere get funding, either through philanthropies or through increased rates or whatever.

Chairman **Rangel**. My problem is that I have not heard, as chairman, testimony from the religious organizations that provide health care that relate to the problems of the poor more than that it relates to the problems of low reimbursement, which is a legitimate thing. But I just hate to see the public hospitals standing alone as the moral leaders of providing health care.

Mr. **Kleyn**. So does the private sector, Mr. Chairman. When people come to our hospital who are unable to pay, we accept those people for care. Just the other day it was very interesting——

Chairman **Rangel**. That was the debate that was taking place here.

Mr. **Kleyn**. That's right.

Chairman **Rangel**. And that is the question that we are debating, as a matter of fact. I thought you were saying that you have a limit as to the number of poor people that you can accept at St. Joseph, based on the contributions.

Mr. **Kleyn**. On budgetary allocations we make, we try to distribute that as equitably as possible for those that come to us.

Chairman **Rangel**. Do the best you can with what you have to work with.

Mr. **Kleyn**. That's right.

Chairman **Rangel**. But unlike the public hospitals, the poor can't depend that they will be admitted.

Mr. **Kleyn**. In most instances we do admit these patients even when they present themselves in our emergency room.

Chairman **Rangel**. Well, I didn't mean to interrupt your testimony. I want you to know, Mr. Kleyn, that that is very unusual. I know because of the unique placement of your hospital in the innercity and perhaps because of your board policy that this happens, but you will have to take my word for it that other private institutions are not that liberal in making that determination at admissions.

Mr. **Kleyn**. I disagree with this in terms of the Denver situation because of all the private hospitals that I know of, each one of them make very specific allocations to distribute and to take care of those that are in need.

Chairman **Rangel**. I am not arguing with you. I am saying that poor people or people who cannot pay are turned away in some cases and this is a fiscal decision. It is not a moral decision, not a medical decision, and I suspect that they would say—well, they have said it in the city of New York. "If we take anymore of these public cases, then we become a public hospital and go bankrupt." And they would rather provide service than go bankrupt.

It doesn't bother me too much except when the spiritual element starts moving in. Then I get confused.

Mr. **Kleyn**. This happened also in Children's Hospital in Denver, whereby because on account of the tremendous increases in health care demands of those who were unable to pay, ultimately had to restrict their admissions policy for the poor. This is true. It strictly was—and you are right—a matter of fiscal survival, because all what they needed to do was to recycle all that increased charity care into the rate structure whereby they affected their competitive position.

Chairman **Rangel**. I just don't like seeing my church get involved in fiscal survival when we are going down the moral drain.

Mr. **Kleyn**. To conclude, part of the complex problem of health care costs is due to the medicare/medicaid inadequate reimbursement system. Since 1966, the benefits have been expanded, the eligibility has been expanded and reimbursement has constantly decreased. It is unfortunate that even in State rate review commissions situations have not been able to include medicare and medicaid payments in their philosophy that all payers must pay the same price. This system would have decreased all health care costs and provided accountability for hospitals.

We just, for instance, completed a study that if medicare and medicaid participated in the reasonable approved financial requirements, we could reduce rates to all nonmedicare and nonmedicaid patients by $32.60 a day. In other words, because on account of the inadequate reimbursement system on medicare and medicaid, the private sector in our particular hospital is subsidizing that patient population to the extent of $32.60 a day. Or based upon an average length of stay of 6.3 days, by approximately $190 to $200 a day per stay.

Chairman **Rangel**. Well, the Federal Government is involved in that subsidizing, too, on tax exemptions and a variety of other Federal benefits, aren't they? In other words, it is public and quasi-public we're dealing with, isn't it? It's all public type of health care to an extent.

Mr. **Kleyn**. Up to a point, Congressman Rangel, because tax exemption really means that the not-for-profit status doesn't mean that the hospital does not have its own financial requirements. It must provide working capital. It must make principal payment on the debt. It must keep up with technology at much higher prices than equipment that was bought 10 years ago.

Chairman **Rangel**. Do you have priorities in terms of a patient that is admitted in any way?

Mr. **Kleyn**. No, we do not.

Chairman **Rangel**. Just the admission office?

Mr. **Kleyn**. Through the admission office.

Chairman **Rangel**. Well, thank you. My questions are really to be informed and I probably will be sending a separate letter to you to be better informed as to how this works because it is clear to me that all of our hospitals can be in trouble and the Government is involved in all of them in one way or the other.

So thank you and thank the good sister for your testimony.

Mr. **Kleyn**. Sure.

[The prepared statement follows:]

STATEMENT OF SISTER MARY ANDREW

Thank you for the opportunity to speak to you. I am Sister Mary Andrew, president of Saint Joseph Hospital, a 550 bed hospital with the largest free standing Graduate Medical Education Program in Colorado, located in the inner city of Denver. I have been in health care for 28 years, 19 of which have been at Saint Joseph. Saint Joseph was the first private hospital and is celebrating its 108th birthday.

I would like to speak briefly to three issues:

1. Nursing Differential for Medicare Patients

   Medicare used to allow a hospital a 2% payment on total costs in lieu of specific recognition for other costs. In 1968, Medicare abolished the 2% payment on total costs and substituted an 8½% allowance on nursing costs only, which meant a decrease in payment.

   In 1981, the nursing differential was decreased to 5%. In 1982, Medicare, because of budget problems, wishes to completely eliminate the differential. This is not just because:

   A. Medicare patients do require more nursing care. They require custodial care as well as acute care when hospitalized. We do try to monitor their care so the level of care is appropriate. We all realize as our population grows, there will be increased Medicare needs.

   B. Hospitals do want to take care of all patients equally. For years we have lived with inadequate reimbursement due to the contractural agreements with Medicare and Medicaid, and have included these losses in rates paid by other patients. Hospitals are then critized for the high cost of health care.

The General Accounting Office is to do a study by February 1982 to determine whether there is any difference in costs for nursing Medicare patients and other patients.

A study done by Health Care Financing Administration (HCFA) concludes there is no evidence available to justify the nursing differential. A second study conducted for Health Care Financing Administration by Lewin and Associates of Washington, D.C., shows that Medicare patients require 10-14% more nursing care per day than all other patients.

We fear the February study to be done by the General Accounting Office will be conducted hurriedly, will not use proper evaluation methods, and will not be objective. If an objective study were done, and showed 10-14% more nursing care was indeed accurate, we wonder what Health Care Financing Administration would then propose.

The elimination of the nursing differential will simply result in the transfer of payments from the public to the private sector, and will increase hospital costs per day. Reduced Medicare reimbursement results in greater Medicare contractual losses which must be recycled in the hospital rate structure and be paid by all other payers of services.

11. Funded Depreciation Investment Income

Ever since the enactment of Medicare legislation, hospitals have been encouraged to fund depreciation. The importance of funding depreciation was given impetus through a federal government incentive whereby the investment income from funded depreciation was not offset against interest expense on long-term debt. As a result thereof, hospitals had an opportunity to build some capital for the replacement of outmoded facilities and equipment as well as mitigate, in part, the ravages of inflation.

A. It is now proposed that for Medicare cost reimbursement purposes funded depreciation investment income is to be offset against interest expense as long-term debt. This will help the federal budget. It will increase hospital costs again and therefore transfer more costs to other payers of service.

B. The Administration speaks enthusiastically about introducing competition among hospitals as a means to control hospital costs. Attached hereto is Exhibit A which demonstrates what happens to hospital prices at various levels of Medicare and Medicaid participation. The exhibit clearly documents that a hospital with an 80% Medicare and Medicaid patient population must increase prices by 80% compared with the hospital which has no Medicare or Medicaid patient population in order to keep its financial viability to provide services. It is ironic that the Congress is presently asked to enact proposals that are counterproductive to the very competition it proclaims.

111. The Care of People Called Medically Indigent

I have attached to my comments a copy of the Denver Medical Society statement concerning medical indigency. We are all trying to assess the magnitude of the problem and solutions for Denver and Colorado. We do not have complete testimony for you at this time but will send you our thoughts.

To conclude, part of the complex problem of health care costs is due to the Medicare/Medicaid needs. Since 1966 the benefits have been expanded, the eligibility has been expanded, and reimbursement has decreased. It is unfortunate that state rate review commissions have not been able to include Medicare/Medicaid payments in their philosophy that all payers must pay the same price. This system would have decreased all health care costs and provided accountability for hospitals.

I appreciate this opportunity to appear before you. I do realize how well you solve many difficult issues. We will continue to work with you every way we can.

EXHIBIT A

Impact of Contractual Losses on Prices

	0%	50%	67%	80%
Revenues	$1,000,000	$1,000,000	$1,000,000	$1,000,000
Costs	800,000	800,000	800,000	800,000
Profit	$ 200,000	$ 200,000	$ 200,000	$ 200,000
Less- Cont. Loss	---	100,000	134,000	160,000
Net Profit	$ 200,000	$ 100,000	$ 66,000	$ 40,000
Revenues	$1,000,000	$1,200,000	$1,406,060	$1,800,000
Costs	800,000	800,000	800,000	800,000
Profit	$ 200,000	$ 400,000	$ 606,060	$1,000,000
Less- Cont. Loss	---	200,000	406,060	800,000
Net Profit	$ 200,000	$ 200,000	$ 200,000	$ 200,000

DENVER
MEDICAL
SOCIETY

DENVER MEDICAL SOCIETY
1601 E. Nineteenth Ave., Denver, CO 80218, (303) 861-1221

REPORT
and
RECOMMENDATIONS
of
THE TASK FORCE ON MEDICAL INDIGENCY

November 5, 1979

INTRODUCTION

In the summer of 1978, the State Legislature's Health, Environment, Welfare and Institutions (HEWI) Interim Study Committee was given the assignment of studying the issue of funding health care rendered to medically indigent people in Colorado and to recommend a State policy. The President-elect of the Colorado Medical Society, Robert B. Sawyer, M.D., was asked to testify on the subject. He indicated that the Colorado Medical Society was in the process of developing policy on the issue.

Dr. Sawyer subsequently asked the Denver Medical Society to assist in the development of policy since much of the care needed by medically indigent people is provided in Denver. He specifically asked for data (1) on the number of medically indigent patients receiving care in Denver; (2) where this care is given—in addition to Denver General and the University Hospitals; (3) what monies, in addition to State funds, are supporting this care?

A special DMS task force was formed to study the issue. The committee reviewed the findings of the staff of the HEWI Interim Study Committee and the testimony given to the committee (contained in the Colorado Legislative Council Research Publication #329, December, 1978), and received information from several consultants, and benefitted from the May 24, 1979 draft chapter on Care of the Medically Indigent prepared for the proposed Colordo State Health Plan of the Colorado Department of Health.

PREMISE

The Denver Medical Society should formulate an opinion with reference to the State of Colorado adopting a statement of public policy with reference to the provision of medical care to those persons deemed to be medically indigent and unable to provide adequate medical care for themselves.

The Society understands that there is an unknown number of persons who (a) are not included in any private or public program of medical care, or (b) are in a program that offers inadequate protection against catastrophic illness.

The Society concurs that, based on the information available to it, there is a need for the development and adoption of such a statement of public policy and that it should be incorporated in the statutes of the State of Colorado.

RECOMMENDATIONS

The following recommendations, listed in sequence, can, if enacted, alleviate the plight of the medically indigent and those who provide for their care. The recommendations are toward moderate improvement and expansion of programs currently in effect.

It must be acknowledged that present programs are fragmented. It is to be hoped that long-range efforts can be directed toward orderly development and implementation of an integrated and comprehensive program of care.

1. THE COLORADO GENERAL ASSEMBLY SHOULD IMMEDIATELY ENACT STATUTORY RECOGNITION OF A MEDICALLY INDIGENT POPULATION AND ASSUME FULL RESPONSIBILITY FOR THE HEALTH CARE COSTS OF THOSE PERSONS.

State appropriated funds currently flow to support the medically indigent by two routes: 1) a footnote in the long appropriations bill providing ten million dollars to participating hospitals and 2) an appropriation of fourteen million dollars to the University Hospitals by the State Education Budget. Other non-state support is derived from 1) the budget of the City and County of Denver and the federal government which supply funds which fill the gap between reimbursement levels and actual cost of supplying care to medically indigent clients, 2) funds provided from the budget of private hospitals, 3) county funds which are usually limited to emergency treatment only, 4) the patient's financial resources, and 5) the resources of the medically indigent patient's relatives.

The fragmentation in the existing system of support seems to imply that the state legislature is reluctant to recognize the existence of the medically indigent population. Estimates of the size of this population is in the neighborhood of 350,000. A method of providing adequate medical care must be developed with attention to the most productive cost/benefit ratio.

Accepting the premise that provision of care for the medically indigent is a state responsibility, whether the citizen resides in a rural or metropolitan area, certain idiosyncrasies of the needs in the Denver metropolitan area must be recognized. The private sector in the Denver area cannot absorb the patient load that would result from substantially curtailing services at Denver General Hospital and the University Hospitals. These institutions are uniquely qualified to provide care to the medically indigent. The State must provide adequate compensation for these services.

2. SELECTION OF A NEW METHOD OF ADMINISTERING FUNDS TO THE MEDICALLY INDIGENT MUST AVOID THE DEVELOPMENT OF PROHIBITIVE ADMINISTRATIVE COSTS.

The administration of the program at the present time is primarily through the State Department of Social Services. It is difficult to make a precise statement regarding current administrative cost, however, examination of the evidence available indicates that the present costs are quite low, e.g., it is estimated that the processing of claims for medical services costs from $2.50 to $4.00 per claim. The current system design does not require claims processing but merely involves submitting a statement of costs to the Department of Social Services on a quarterly basis. This statement is subject to audit. A new system providing the benefits of consolidated administration might also produce administrative costs of 10% to 15%. Such a system could represent a prohibitive erosion of the funds available for medical care.

3. STATE LEGISLATION TO RAISE THE POVERTY LEVEL INCOME LIMITS SHOULD BE SUPPORTED.

People presently under the poverty level income limits receive Medicaid. The state pays approximately 50% and the federal government approximately 50% for these costs. In addition to meeting the income level requirements, a person receiving Medicaid must fall into one of the categories for treatment. This includes OAP - Old Age Pension, AFDC - Aid to Families with Dependent Children, AND - Aid to the Needy Disabled, AB - Aid to the Blind, and CW - Child Welfare (foster care).

The present income limit for a family with one parent and two children is $3,330.00 per year and the limit for a family with two parents and two children is $4,211.00 per year. Individuals meeting these income limit requirements and falling into one of the categories listed above, receive free medical care under Medicaid and cash payments. It is recommended that the income limits be raised to include a larger population and that this group (the medically needy—see Title XIX, sec. 2) be provided with medical care, but not with cash payments.

4. FEDERAL OR STATE LEGISLATION TO PROVIDE CATASTROPHIC HEALTH CARE INSURANCE SHOULD BE SUPPORTED.

With such a system in place the number of people reaching a "medically indigent" status by way of "spend down" of financial resources would be diminished.

5. A METHOD OF IDENTIFYING MEDICALLY INDIGENT INDIVIDUALS AND TRACKING THEIR BEHAVIOR IN ACQUISITION OF MEDICAL CARE SHOULD BE DEVELOPED.

The identity and the behavioral characteristics of the medically indigent are largely obscured by their life style and by the absence of a "tracking" system. It seems likely that a large portion of funds provided for medical indigency may be wasted by duplication of services for the same patient, admission to "expensive" hospitals for routine obstetrical care, over-utilization of emergency rooms, etc.

Some HMOs have demonstrated with Medicaid contracts that efficiency can be achieved in dealing with socio-economically disadvantaged people. A useful parallel may exist with the medically indigent population if one is able to identify and track behaviors.

6. GROUP HEALTH INSURANCE SHOULD BE MADE AVAILABLE TO A HIGHER PERCENTAGE OF THE POPULATION.

A large portion of the rural population of the state is not eligible for group health insurance due to the nature of their employment. The purchase of individual policies may be a prohibitive expense, thereby placing these individuals in a marginal state of medical indigency. These people could be eliminated from the roles of the medically indigent if the insurance industry would provide group rates for rural people. A mechanism of providing this type of insurance coverage should be a legislative mandate. Similarly, in urban communities there is a need for the availability of group health insurance for the marginally employed and/or those who are otherwise ineligible for any existing insurance coverage.

REPORT

BACKGROUND INFORMATION

Medicaid

To be covered by the Medicaid program in Colorado, a person must qualify for at least one of the five programs of "categorical aid":

Aid to Families of Dependent Children (AFDC)
Aid to Needy Disabled (AND)
Aid to Blind (AB)
Child Welfare (CW)
Old Age Pension (OAP)

GLOSSARY OF TERMS

Indigent - impoverished - lacking in means for basic sustenance of life.

Medically Indigent - lacking in means for payment of medical care (not eligible for Medicaid because of income and/or not meeting requirements for categorical aid programs [i.e., single or married and employable] or awaiting certification of eligibility for Medicaid which may take as long as 90 days.

Poverty-Level Threshold - arbitrary income limit established in conjunction with size of family and utilized to determine eligibility for categorical aid.

Categorical Aid Programs - as defined by the Department of Social Services:

(AFDC) Aid to Families of Dependent Children
(AND) Aid to the Needy Disabled
(AB) Aid to the Blind
(CW) Child Welfare
(OAP) Old Age Pension

To be eligible a person or family must fulfill the eligibility requirements of a means test (an arbitrary income limit established in relation to size of family) and meet certain social status requirements (i.e., AFDC - requires a fatherless household or an unemployable father).

Medically Needy - those who fulfill social status requirements for categorical aid programs but are ineligible for Medicaid coverage due to income restrictions *only* (i.e., income exceeds by $1.00 the maximum income allowed for cash maintenance benefits in categorical aid programs).

Spend-Down Principle - expands concept of eligibility for tax-supported medical care coverage to include consideration of the percentage of individual or family income expended for medical care, in addition to total income and size of family.

Universal Coverage for Medical Care - provides services to a total population without income qualifications.

Categorical Coverage for Medical Care - refers to assistance provided to a select group of patients by diagnosis (also known as "targeted approach").

Comprehensive Coverage for Medical Care - describes full service coverage to be provided in a medical care program. Comprehensive coverage can apply to a universal or a categorical population.

Catastrophic Illness - illness which, due to cost, can pauperize a patient and/or family.

Patient/client access to the Medicaid program is through the establishment of eligibility for one of the above programs.

Medically Indigent

The population not eligible for Medicaid, includes (1) single individuals, (2) couples with no children, and (3) the elderly living on social security whose income exceeds the current level of the old age pension allowance and who have no insurance coverage. The HEWI Committee research health document estimates that there are 170,000 such persons in Colorado. These are people whose medical care is provided without charge or at a nominal fee.

Historically, care was provided to this group by Denver General Hospital for residents of the City and County of Denver and by the University Hospitals for all other residents of the State. City tax monies support care through Denver General; State tax monies reimburse the University Hospitals.* The flight to the suburbs, accelerating in the early 1970s, and adoption of the Poundstone Amendment to the Colorado Constitution, severely limited Denver's annexation potential. Denver's tax base declined in relation to the population being served although Denver services (i.e., Health and Hospitals, Zoo, Museum, etc.) continued to be provided. Mobility of the patient population within the burgeoning five-county metro Denver area increased the difficulty and cost of establishing eligibility for care according to resident status.

The residents of the City and County of Denver raised an objection to double taxation (City and State) for medical care of the medically indigent. In 1974, the State Legislature appropriated money for reimbursement of Denver General through the State Department of Social Services to be paid out on a case-by-case basis. Thus, establishment of fiscal responsibility for the provision of medical care was initiated as a tax equity issue, not as a medical care issue.

For fiscal year 1978 (FY '78) the Legislature allocated $10 million for reimbursement of participating hospitals for care of this population by a footnote description in the Long Appropriations Bill. (Of the total $10 million, only $100,000 was earmarked for reimbursement of physician services.) The reimbursement rate provided in this appropriation is conceded to be less than 50% of actual cost. Ninety-three percent of the $10 million was paid during this year to the Denver Department of Health and Hospitals. That Department explains its ability to provide care for less than the actual cost of $22 million because it has a program and system in place (supported by Federal, State and County funds) which for the time being has been able to absorb the substantial cost differential. It is believed that few private hospitals could afford to participate in the program to any significant extent because of the low reimbursement rate. The only means by which private hospitals could afford to participate is through reimbursement of actual cost or by recovery of the differential through a raise in rates to private or commercially-insured patients.

The major facilities providing most of the care to medically indigent people continue to be the University Hospitals and Denver General Hospital. The University of Colorado Health Sciences Center budget, emanating from the Department of Higher Education, includes $14 million in direct appropriation for teaching purposes which is applied to the clinical program for indigent care. (UCHSC states FY '78 expenditures for care for the medically indigent totalled $17 million, thus creating part of the fiscal crisis at the University Hospitals.)

A recent Colorado Hospital Association survey of Colorado hospitals, as to the expenditures for care of the medically indigent, yielded a figure of $24 million for this same period. All Colorado hospitals, whether or not recipients of Hill-Burton funds, are required to devote 3% of their total annual budgets to "charity care" if they choose to participate in the medically indigent program. Some expenditures for care of medically indigent people in FY '78 included:

$10 million at Denver General Hospital
$14 million at University Hospitals

and the required percentage of care from Hill-Burton funded hospitals.

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*Prior to the depression years of the 1930s, "charity care" in Denver was provided to the needy on a voluntary basis through private hospitals and such privately-funded facilities as Ave Maria Clinic. In similar fashion, privately funded social agencies met economic needs. The overwhelming numbers of citizens affected by unemployment in the 1930s resulted in a rather rapid escalation of the assumption of responsibility on the part of the Federal, State and local governments during the Roosevelt era to meet basic human needs (food, shelter and clothing). Following World War II, the Federal government, through the Hill-Burton Act, provided heavy subsidization of private non-profit hospitals to encourage expansion of medical programs. In partial payment, such hospitals were required to provide some care to the medically indigent. Meanwhile, pressures were building to include health care as a right of all citizens equal to the right to coverage of basic human needs. Ultimately, the Congress established that right to health care for specified groups of citizens through passage of Medicare and Medicaid legislation in the 1960s.

The University Hospitals' in-patient and out-patient "ability-to-pay-scale"—adjusted each year on July 1—is the most frequently used guideline for determination of eligibility under the medical indigency program. Income and size of family, together with the United States Department of Labor Poverty Level guidelines, are used to determine eligibility for free and part-pay care as well as the amount.

The medically indigent population is a group which, with rare exceptions, has traditionally been outside the mainstream of nearly all human services. They are often referred to as the "working poor." These are people at the lowest rung of the socio-economic ladder with minimal work skills, sporadic work histories, a high mobility rate and multiple social problems. As a group they tend to be less educated, more poorly housed and fed and with less capacity to cope with the present-day world than the average of the population.

Those experienced in working with this group report that the need for the use of ancillary medical and social services exceeds by far the need for physician services despite a precipitating problem of illness. This is a group of patients for whom a private practicing physician may—for professional and humanitarian reasons—wish to provide care on occasion. However, as aptly stated by one member of the task force, "You can't give such people medical service without buying ancillary services for them out of pocket." Diagnostic and treatment modalities of modern medicine using X-ray, laboratory and other contemporary techniques require a mechanism for reimbursement.

It is speculated that, in part due to the mobility of the medically indigent, much duplication of service to the same group may exist although, at present, no system has been developed to track the medical encounters of this population. Further it should be noted that it is, in part, the unmet needs of this group that have triggered some of the emotional drive towards development of a national health insurance system for this country.

MEDICALLY NEEDY

One portion of the medically indigent population includes some people whose incomes are just barely above the limits established to determine eligibility for the categorical aid programs. They are referred to as the medically needy. For example, a mother with three children with an income of $6,000 to $7,000 is excluded from the Aid to Families of Dependent Children program and therefore Medicaid. The numbers of such individuals cannot be ascertained with any degree of accuracy.

The Federal requirements for States to be eligible for participation in the Medicaid program list five services that must be available to all persons so covered: in-patient services, out-patient services, skilled and intermediate care in nursing homes, physician services and a home health care program. The Colorado Medicaid program meets these criteria.

Medicaid guidelines issued at the Federal level permit a State to set its own poverty-level threshold. For example, if the State of Colorado were to raise the poverty-level threshold for a family of four to $7,500 (instead of $6,200) an unknown number of families would qualify for the Medicaid program.

There are arguments for and against the State moving in the direction of accepting a larger number of Medicaid patients by raising the poverty-level threshold. Those who favor this action point out the availability of additional Federal dollars and argue that 53% of Medicaid costs would be reimbursed by the Federal government and therefore the State would benefit. Opponents of such an expansion of Medicaid services point to the experience in some States where costs have gotten out-of-hand, probably due to the inclusion of the nursing home care provision; in Colorado 41% of Medicaid expenditures are for nursing home care. In any event, movement of the poverty threshold upward would result in fewer people who are not covered by a medical care program of some kind.

SPEND-DOWN PRINCIPLE

In recent years, and more specifically within the HEWI committee of the Legislature, concern has been expressed regarding the limits of an eligibility formula which is restricted to amount of income and size of family as the determinants of need. There has been an increasing public awareness that a major illness can, and does, result in pauperization of a family. An extreme example is the impact on family lifestyle and income should a family member require costly renal dialysis. The spend-down principle, in brief, would add a third variable—the impact of extraordinary medical expenses—to the determination of eligibility.

This increasingly popular principle would enlarge the group of persons qualifying for classification as medically indigent and would increase dollar costs. The major problem, obviously, will be to devise a workable formula.

The public policy issue to be resolved is whether or not it is in the public interest to prevent pauperization of families due to extraordinary medical costs.

The next issue that arises is whether categorical or comprehensive coverage of medical care should be applied. Proponents of comprehensive coverage suggest any other method will add to administrative costs and further fragment the delivery of service. Proponents of categorical coverage suggest that the comprehensive approach would be prohibitively expensive, and thus not be practical.

Some of the issues addressed by the State Legislature in discussing the feasibility of the spend-down principle find their counterpart at the National level in the debate on need for catastrophic health insurance.

COMMENTARY

Any consideration of a statutory program to provide care for medically indigent people (non-Medicaid eligible) raises the question of who should administer the program and in what manner. The Department of Social Services has sole responsibility for establishing the eligibility of persons qualifying for categorical aid (AFDC), et al) and for reimbursement of hospitals and of physicians providing care for Medicaid and medically indigent programs. The Department suggests that it can administer an expanded medical indigency program with minimal additional administrative cost because it can "piggy-back" on the existing structure and it will be unnecessary to hire additional personnel. Legislators and others suggest that a different method of administering the program must be attempted. At issue, in part, is the question of centralized versus local control. This is best exemplified by opposition to the present need for most communities to refer medically indigent patients to the University and Denver General Hospitals. There is increasing pressure to develop some program that would permit persons needing medical care to be served in their local communities, recognizing that, for more complicated illnesses, referral to the urban center hospital will at times be necessary. Presently, counties are carrying the full responsibility for administering welfare programs with only a modicum of State supervision. However, the counties contribute very little in the way of funds to the programs (at most, 20%).

One recent legislative proposal would have placed responsibility for implementation of the program within the State Health Department and model it upon the Handicapped Children's Program in which purchase of physician and hospital services is made by the Health Department, when possible, within the community where the patient resides. The criteria for selecting the local hospitals and physicians would include judgments of quality and cost-effectiveness. Such contractural relationship between designated providers and the State Health Department would be reviewed annually. The bill would have incorporated the spend-down principle. It would have made possible either comprehensive coverage or categorical coverage as a departmental decision within the limits of available funds.

It should be noted that, in reviewing all of the above issues with respect to medical indigency programs, there is a limitation imposed by what is known as the Kadlecek Amendment which prohibits the Legislature from appropriating more than 107% of last year's overall expenditures for State-funded programs. Therefore, any new program would presumably involve a shift to existing monies and a comparative evaluation of cost/benefit ratios.

NOTE OF EXPLANATION

There is a difference in the numbers of estimated medically indigent persons listed in the Report and in the Recommendations.

The figure of 350,000 medically indigent was used at the conference on **Health Care Financing Options**, September 24-25, 1979, sponsored by the Colorado Department of Health. As noted, the figure of 170,000 such persons was taken from Colorado Legislative Council, Research Publication, #239, December 1978.

MEMBERS OF THE TASK FORCE

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David Howe, Deputy Manager, Finance and Operations, Denver Department of Health and Hospitals
Eric Munson, Director, University Hospitals
Thomas Parshall, Director of Financial Services, Saint Joseph Hospital

Chairman **Rangel**. Ms. Schoen.

STATEMENT OF CATHY SCHOEN, SPECIAL ASSISTANT TO THE PRESIDENT, SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO

Ms. **Schoen**. Thank you, Mr. Chairman.

My name is Cathy Schoen. I am the special assistant to President John Sweeney of the Service Employees International Union.

On behalf of SEIU's 675,000 members and our president, I thank you for this opportunity to testify on the unfolding stories of human suffering which are direct results of inhumane and backward Federal budget cuts and program changes.

Our testimony today is based on reports from our members. SEIU's health and public employees, roughly two thirds of our membership, see and experience firsthand the injustices occurring today and the unnecessary deprivation in America's health care system.

In addition, many of our members, themselves, have only recently fought their way out of poverty. Our members work in building services as custodians, food service workers and other private industry service jobs find they struggle each year to get wages that barely allow them to survive. Thousands of our members do not have any health care coverage at all. They depend on public hospitals and they depend on public health centers.

The stories that I am going to try to go briefly through are based on reports from health care workers in the public institutions and from our members who rely on these institutions because they are uninsured patients. They are the working poor.

I am going to run briefly through our testimony and trust the rest of the testimony can be submitted to the record. A lot of what is in here repeats some of what you have heard from our employers, the public hospital administrators who were sitting here on the first panel.

In Chicago, as you have heard, Cook County Hospital is a disaster area. In people terms, this has resulted in periodic crises for our employees. Two years ago, our members worked for 3 weeks without any pay. Their commitment to continue to deliver services even when the hospital ran out of money, meant that they came to work every day. That meant that they, themselves, didn't have any health insurance coverage during that period.

Right now the patient transfers that you have heard about, we have been counting them to be about 200-300 patients transferred a month over last year, mean that our emergency room people are reporting long waiting lines and serious staff overloads.

Chairman **Rangel**. How are they transferred?

Ms. **Schoen**. Well, they arrive in various ways. Some of them come by ambulance. Some of them are walkins saying that they couldn't get into another hospital. One of our locals, when I was calling them, told me that they just had admitted a man from Arkansas who, while having a serious asthma attack, had to make the long trip to Cook County, which took him 9 hours in his car. He tried to get into three different hospitals and none of them would let him in because he didn't have any health insurance. That person just walked in.

In other parts of Chicago, our low-income workers are reporting to the other side of this. They are being laid off and they are having to go to the public hospital and experiencing the long waiting line. And they are being turned away from private hospitals because they can't get into those facilities.

Detroit, Mich.—as you know, Michigan, itself, is a disaster area. Employment rates are zooming up to about 15 percent in the major cities. This means that where we are working in private hospitals, we are experiencing huge layoffs. We had 200 people laid off at Harper Grace Hospital in southwest Detroit, a hospital serving a largely black community. Right now the hospital has got 130 beds. They are down to an 18-person census. And throughout our nursing home locals and throughout the other hospitals, people are being asked to reopen their contracts to take wage cuts.

And I might point out, talking about wages, nursing homes are averaging—and these are unionized wages—$3.60 an hour to $4 an hour. Our people don't have any health insurance. They are getting laid off. They are lowering their wages and they are turning to public hospital systems that are increasingly unable to take care of them.

In Michigan, when I called them, they said,

> You know, these aren't even the Federal budget cuts yet. We haven't even seen them yet. Always in the past we have hoped that at least the Federal programs would pick up some of the slack when we went into recession and act as a counterbalance.

That whole cushion is going to be removed right now and it is going to go the way it went in the 1930's, where Federal policies withdrew just when the private system was collapsing, as well. It is swinging the pendulum further out.

In Connecticut, our sister union, District 1199 out of New York, represents the public hospital workers. They also report that right now they are already dealing with major deficits in the State before the big Federal cuts hit them. Some of what they have been seeing are what I would call irrational cuts you heard about earlier today. Community nutritionists and dietitians are being laid off, people that were delivering preventive basic nutritional services to keep people out of hospitals.

Adult day care centers have closed off their patient list throughout the State of Connecticut. What this means is if you have a family member who needs to be put in a day care center during the day for some health services, you can't get a new person in anymore. You have to put them in a nursing home. It is going to cost a lot more money in the long run.

Neighborhood health centers are laying off their nurse's aides and they are trying to maintain at least their nurse practitioners but practitioners now can't take care of the patients they used to be able to take care of because they don't have any nurse support staff.

In our mental hospitals which also I consider public hospitals, administrators are starting to try to shift staff back and forth on various wards so that at any time they are meeting Federal standards for staffing even while they are allowing people to be laid off, and this is placing incredible stress on the workers who are working in those institutions. The workers compensation load has gone way up for health care workers. It is usually quite low. In one hospital alone we have 1 out of every 10 nurses on workers comp for stress and where patients are abusing the people who are taking care of them. And this is again going on before all the big cuts.

In California you have heard a lot about southern California. The same sorts of stories are coming out of northern California, as well. Our San Francisco social services local is reporting major layoffs. Five hundred workers have been laid off and these people were all providing services to abused, learning disabled, handicapped, foster, and other disadvantaged children. A full half of the social services department has been reassigned. Right now you've got cases where the people who were delivering direct services have been laid off and supervisors who haven't delivered services in 15 years are the only ones left to take care of families that need help.

This has started to show up fairly early as higher incidence of health problems. We have seen a lot of serious child abuse, children arriving at hospitals mutilated and seriously maimed, a few horror stories of people arriving dead who had formerly had a social worker assigned to the family. The worker was removed although the family had a chronic history of child abuse.

In southern California, you again heard some of the statistics on what they are doing. I want to briefly talk a little bit about what is happening in some of the health centers and hospitals. We represent the workers of Watts Health Center which is in Watts, a high-poverty area of Los Angeles. They are staggering under a 25- to 50-percent cut in their budget and have laid off some 90 out of 300 workers, about a third of their work force.

They are now starting to turn people away whom they could have given primary care to and sending them to emergency rooms in hospital outpatient departments.

In Martin Luther King Hospital, which is the public hospital, county officials have closed down the renal dialysis unit and the pharmacy unit. I didn't have time to get it in my written testimony, but we also have reports that pediatric walkin services are going to be closed down, as well.

At Rancho Los Amigos, which is a public rehabilitation center for permanently disabled people, one-half of their funds for TB wards have been cut back and as Ms. Dallek reported to you, the TB incidence in LA is on the rise. Yet we are seeing both the workers who are delivering TB services and people who need it are being turned away.

Across the county, the residents have organized a communitywide health care alliance but so far the best they have been able to do is keep this all in the courts to at least stop some of the most serious closures from happening. But the county is laying before us massive deficits and they are saying, "Well, how are we going to deal with this?"

In Denver, my last case story, our people represent food services and custodian workers, as well as health care workers. But what they wanted to impress on you is that these people, and these are full-time workers, do not have health insurance. We have union rates for these jobs of roughly $4.40 to $4.70 an hour and people have not been able to pay for health insurance. So Denver service workers rely on neighborhood health centers and the public hospitals in Denver. They report to us that they might, even if they had health insurance, use these services out of choice because Denver provides a very high-quality system. They are asking us, "What is going to happen to us when these places close down. We know we can't go anywhere else."

I could bring in our local who could supply you with names of people who can tell you about being turned away from places. I am not sure it is this gentleman's hospital [St. Joseph's], but most Denver residents have found that the public system is the only one that will take them when they go and say, "I have no health insurance," and they show them what they are making in annual wages.

These were just a few of our city examples. I wasn't able to give you a full list. But I did want to give you a glimpse of what has already started to happen before what we calculate is roughly $3 billion in Federal funds is going to be taken out of the health system this year before the next round of cuts.

We heard from other unions that in New York City they are seeing increasing emergency room use around mealtimes. These people have lost their food stamps and they are coming in hungry. So the health care system is sort of a cushion for a lot of problems, not just medical ones. And it is hard to turn a hungry person away from a hospital.

We hope that this brief overview of today's systems crisis will renew a broad congressional commitment to provide a basic level of health services which should be the right of all residents in our wealthy and supposedly civilized society.

On behalf of SEIU, I thank you for this hearing. We urge you to do whatever you can to avert a wholesale destruction of our flawed, yet vital health system.

I assure you, and John Sweeney, the president of SEIU assures you, we are going to try to do everything we can to build coalitions, educate and bring pressure on Congress to get us back on the track of moving forward. We hope it is in a direction of something like national health insurance. But at least we must get back to a health care system that talks about services based on peoples' needs, not whether they have a health ID card when they present themselves.

Thank you very much.

Chairman RANGEL. Thank you very much.

[The prepared statement and additional information follow:]

STATEMENT OF THE SERVICE EMPLOYEES INTERNATIONAL UNION, AFL-CIO, CLC

Good afternoon Mr. Chairman and Committee Members.

May name is Cathy Schoen. I am the Special Assistant to President John J. Sweeney of the Service Employees International Union.

On behalf of SEIU's 675,000 members and our President, I thank you for this opportunity to testify on the unfolding stories of human suffering, waste and financial crisis in the U.S. healthcare system which are direct results of inhumane and backwards federal budget cuts and program changes.

SEIU's members see and experience firsthand the injustice and unnecessary deprivation of America's health system. As staff of the nation's hospitals, nursing homes and health centers -- some 250,000 SEIU members work in the healthcare industry -- and as public servants in state, county and city human services programs -- we represent over 230,000 public employees -- SEIU delivers vital health and social services across the country to senior citizens, the disabled and other low-income and disadvantaged families.

Many of SEIU's members themselves have only recently fought their way out of poverty. It is a disgraceful fact of life in the U.S. service sector that average wages for full-time, year-round workers of $4.00 to $6.00 per hour fall at official poverty levels. Service workers are the working poor; the families left out of the American promise of a decent standard of living for everyone willing and able to work.

SEIU members in the building services working as custodians, food service workers, and other private industry service jobs find they must struggle each year to keep wages and benefits near survival levels. With unionized wages for building services running $4.00 to $5.00 per hour, healthcare coverage must be sacrificed to meet food and housing needs. Thousands of SEIU members depend on public health centers and hospitals as their only source of health care.

To give this Committee some idea of what the budget cuts are doing to healthcare, we have gathered the following stories of experiences of members around the country where they work in health facilities and where they are the low-income families in need of publicly supported health services.

Access to Care in Danger

The picture our people paint of healthcare for families on the lowest rung of the economic ladder is frightening. Although the impact of the massive $3.0 billion plus cuts in federal support of healthcare services has barely begun to hit community facilities, in city after city we see facilities on the brink of collapse. Once the full weight of the budget ax falls, unless Congress acts, we will see wholesale closures and repeated horror stories of people suffering and even dying due to lack of care. Our city, county and state governments simply do not have the resources to come to the rescue without a renewed federal partnership and commitment to provide essential healthcare.

Chicago

Cook County Hospital is the major provider of health services to low income and uninsured families in the Chicago area. The hospital's chronic lack of resources surface as periodic funding crises.

Just two years ago the hospital's operating deficit reached $40 million due to a dramatic increase in patients without health insurance or any public coverage. As a result of this crisis, SEIU members worked for three weeks without pay in November 1979 waiting for emergency loans to come through. That crisis was finally solved by an infusion of local tax funds, bringing operating subsidies for uninsured patients to over 39% of the hospital budget.

Now, in 1982, SEIU members are seeing the makings of a major new threat to the hospital's survival. Workers in the emergency room report waiting lines and serious staff overloads. Each day the number of patients transferred from other hospitals because they are uninsured mounts. The most recent count documented an additional 200 to 300 transfers per month.[1]

One of our locals reported to us one patient's story of trying unsuccessfully to find care from other hospitals before coming to Cook. The man was in Arkansas when he had a serious asthma attack. After three hospitals turned him away, he somehow made the nine hour trip to Chicago and Cook County.[2]

Elsewhere in Chicago we are seeing the other side of cuts in eligibility for public insurance programs. Our local reports loss of patients in all hospitals and layoffs. The combination of restricted Medicaid eligibility due to federal and state rule changes, and the rise in unemployment has created a ripple effect on uninsured patients unable to pay for care throughout the city.

Detroit

Michigan itself is a disaster area. With unemployment raging near 15% in its major cities, SEIU healthcare workers are struggling to survive and continue to deliver services.[3]

In Harper Grace Hospital in Southwest Detroit we have lost at least two hundred people to layoffs. The hospital's once filled-to-capacity 130 beds are now down to eighteen patients.

Our members around the city live in fear that they too will no longer be able to receive care in their own facilities. All our members face cuts and freezes at the bargaining table.

In nursing homes the situation is perhaps even more desperate. Several of our homes are pleading poverty and asking us to break out contracts. Staffing is at bare minimum levels. Now employers try to hide vacancies to avoid being out of compliance with state standards.

Layoffs or reductions in wages in homes paying only $3.60-$4.00 an hour will add still more families to the toll of Michigan's depression healthcare system.

And, our Michigan local stressed, "this is all happening well before the federal cuts hit." Always in the past the state could rely at least partially on federal health expenditures to act as a counterbalance to the swings in private health insurance coverage due to recessions. Now for the first time in almost twenty years, federal health programs will exacerbate depressed economic conditions and hasten health facility bankruptcies. For Michigan the world looks very much like early 1930's when federal policies were going in the wrong direction.

Connecticut

SEIU's sister union, the National Union of Health and Hospital Employees (District 1199), represents health department and social services workers in Connecticut.[4]

The State of Connecticut is currently in the process of deciding what to do with an $83 million dollar budget deficit. As in Illinois and Michigan, well before the impact of federal cuts hits programs, workers are reporting major reductions in services and access to decent care for connecticut's low income and disadvantaged families.

Many of the cut-back decisions will hurt not only access to care but, in the long run, will also prove costly to state and federal programs. The health department has been laying off community nutritionists and dieticians. These people work with families and health facilities to correct basic nutritional deficiencies which might otherwise lead to costly medical programs problems.

Adult day care centers have announced closed patient lists. Any new families with aging family members in need of day care will now have to resort to nursing homes, a far more expensive source of care.

Neighborhood health centers have drastically cut back on nursing aide assistants to nurse practitioners. As a result, practitioners have had to cut back on the care they give to their patients and turn people away.

In mental hospitals, administrators are currently leaving essential positions vacant and then shifting workers back and forth between various wards to meet federally mandated minimum staffing standards. In addition to cutting access to primary and preventive health services, the staffing shortages and double shifts are producing severe stress and consequent health problems among healthcare workers in Connecticut. Throughout the state, Workers' Compensation cases have increased dramatically for health workers. In Norwich State Hospital one out of ten nurses recently were out on compensation. This extraordinary rate directly reflects the occupational hazards of trying to do a good job with too little time and too many patients.

California

California SEIU members throughout the state report drastic reductions and chaos in city and county health and social services delivery to low income families.

San Francisco social services and health support services have been particularly hard hit.[5] Layoffs and wage and hour reductions have hit over 500 workers who were providing services to abused, learning disabled, handicapped, foster, and other disadvantaged children. A full half of the Department of Social Services has been reassigned. In many instances supervisors who have had no direct contact with families in fifteen years are now the only people left to provide services.

Loss of experienced and dedicated staff have translated directly into reduced services. The county no longer has the ability to license new foster homes, monitor the food and cleanliness standards of boarding homes, provide twenty-four hour child emergency assistance (primarily for abused children), or provide home services to people who would otherwise be put in institutions.

The lack of family support services is taking its toll on the health of northern California's children. The incidence of serious child abuse and seriously maimed children has increased with appalling frequency.

Again, our social services local pointed out that this cost in human suffering is merely the tip of the iceberg. The impact of AFDC, food stamps cuts and an anticipated 10% cut in California's medical program are yet to be felt.

SEIU healthcare workers in Southern California report wide-spread closing of vital health services. In Watts, a high poverty Los Angeles neighborhood, the Watts Community Health Foundation is staggering under a 25 to 50 percent cut in budget funds. By December, 90 out of some 300 Watts healthcare workers had been laid off. This massive reduction will hurt the entire health community. Watts, along with other community health centers around the country, has a long track record in keeping people out of emergency rooms and hospital outpatient departments by early, easy access to primary healthcare services.

These cuts also mean clear disaster for Watts' workers whose wages were at poverty levels. In 1979/80, annual wages ranged from $7,404 for housekeepers to $9,492 for licensed vocational nurses. In stark contrast, in the same year the Bureau of Labor Statistics' bare-necessities budget for Los Angeles was $13,399. Loss of their jobs plus loss of Watts' services will severely impair these SEIU members' ability to meet their and their families' need for health services.

Not only have budget cuts crippled Watts, expected shortages in budget deficits have led Los Angeles County supervisors to slash services in the Watts' community public hospital, the Martin Luther King Hospital (MLK). Recent reductions have forced MLK to close down its renal dialysis unit and pharmacy. Pediatric walk-in services have been almost eliminated. Still more closed services are in the works.[6]

SEIU nursing home workers in California have been early victims of the budget cutting mania. Despite wages of $3.75/$4.00 per hour, homes are demanding wage rollbacks from our members.[7] With turnover rates in excess of 200% per year already, according to official California statistics, any wage reductions would have the double-edged effect of further impoverishing our members and making them totally dependent on even more scarce public health programs. Few members have insurance now and none have coverage for their dependents. The plight of SEIU nursing home workers is vivid testimony to the irrationality of starving public programs employees' wages and then talking about private responsibility for health coverage.

Throughout the Los Angeles County health system the cuts have already been staggering. One thousand county healthcare jobs have been eliminated : eight clinics and ambulatory care at thirty-two clinics for 460,000 patients have been shut down; the T.B. wards at Rancho Los Amigos, a leading rehabilitation center for permanently disabled people, have been cut back by one-half; and the list goes on. Now county officials are predicting a further multimillion dollar loss in funds. County residents in a countywide health alliance are desperately trying to fight this onslaught.[8]

Denver

Our Denver SEIU local represents food services and custodian workers, all low income families.[9] Our local union officials particularly welcomed the hearing in their city to tell your Committee how much such low income workers value publicly supported health services. Union rates for these service jobs average $4.40 to $4.70 per hour. Custodian jobs have no health insurance; food service jobs have some minimal coverage for employees but none for dependents. Our Denver members depend on and give good reports on this city's system of neighborhood health centers with its public hospital backup. Local union officials are here with me today and have offered to give you firsthand statements for the record on what major cuts in these programs will mean for SEIU Denver families. Simply stated, there is nowhere else for our members to go if services close down once Medicare, Medicaid and health center cuts hit Denver full force.

Summary

The above city examples cover the range of service cuts SEIU members are suffering and seeing in their facilities. Other unions in New York report an increase in emergency rooms use during mealtime by hungry families as yet another stress on the public healthcare.

SEIU hopes this all too brief overview of today's system crisis will help renew a broad Congressional commitment to provide the basic level of health services which should be the right of all residents of our wealthy, supposedly civilized society.

On behalf of all of SEIU I thank you for this hearing. We urge you to act now to avert a wholesale destruction of our flawed, yet vital, health system.

Footnotes

1. Cook County hospital statistics come from the Hospital Department of Finance and Linda Punch, "Public Hospitals Straining to Survive Federal Assault in Healthcare Costs," Modern Healthcare, December 1981.
2. Healthcare worker information from SEIU Local 73, Chicago.
3. Information from SEIU Local 79, Detroit.
4. Information from 1199, Connecticut.
5. Information from SEIU Local 535, San Francisco office.
6. Information from SEIU Local 660, Los Angeles.
7. Information from SEIU Local 399, Los Angeles.
8. Information from SEIU Local 660, Los Angeles.
9. Information from SEIU Local 105, Denver.

CHIEF ADMINISTRATIVE OFFICER
COUNTY OF LOS ANGELES
713 HALL OF ADMINISTRATION / LOS ANGELES, CALIFORNIA 90012
974-1101

December 11, 1981

HARRY L. HUFFORD
CHIEF ADMINISTRATIVE OFFICER

MEMBERS OF THE BOARD
PETER F. SCHABARUM
CHAIRMAN
KENNETH HAHN
EDMUND D. EDELMAN
DEANE DANA
MICHAEL D. ANTONOVICH

HONORABLE BOARD OF SUPERVISORS
County of Los Angeles
383 Hall of Administration

Dear Supervisors:

HEALTH SERVICES 1981-82 FINANCIAL OUTLOOK
(APPROPRIATION ADJUSTMENT 4 VOTE)

On September 8, the Board approved the recommendation of this office and the Director of Health Services to schedule Beilenson Hearings for December 15, 1981, and to post appropriate notices identifying potential health services reductions. That recommendation was made with the understanding that there were many uncertainties, particularly with regard to Federal and State budget reductions, and that we would be reporting back to the Board with a clearer financial picture prior to the hearings.

While some of these uncertainties still exist, our present estimate of the financial condition of the Department of Health Services indicates that there is a projected overexpenditure of approximately $35.8 million for this fiscal year. This overexpenditure is partially offset by the receipt of unbudgeted revenue from the State in the amount of $14.3 million, leaving a net financial problem of $21.5 million for this fiscal year.

	1981-82 Allowance	1981-82 Estimated Actual	Projected Deficit
Gross Appropriation	$ 921.0	$ 956.8	$ (-35.8)
Revenue:			
Budgeted	783.9	783.9	--
Unanticipated State Funds	--	14.3	14.3
Net County Cost	$ 137.1	$ 158.6	$ (-21.5)

Basis of Deficit

The projected overexpenditure of $35.8 million for the current fiscal year can be attributed to the following factors:

	Net County Cost ($ in Millions)
-- Initial delay in implementation of curtailments	$ 6.0
-- Delays resulting from various court orders temporarily restraining implementation of curtailments ($7705544/[illegible])	3 mos. [illegible] 16.5
-- Overexpenditure of the alcohol and drug program budget in anticipation of additional State allocation	3.8
-- Less than anticipated savings resulting from layoff of temporary employees	4.0
-- Unanticpated costs in connection with recruitment of critical patient care positions	5.5
TOTAL	$35.8

Financing of Deficit

This total deficit could, on a largely one-time only basis, be funded as follows:

Added State Aid		
Ongoing	$ 2.5	
One-Time Only	11.8	
		$14.3
Ongoing Adjustments (staff attrition, efficiencies, and increased collections)		7.9
Temporary Adjustments (employee leaves and expenditure deferrals)		13.6
TOTAL		$35.8

The ongoing adjustments are:

-- Continuation of the present selective hiring freeze on other than direct patient care positions	$4.0
-- Increase up front collections at comprehensive health centers	1.5
-- More effective use of departmental resources	2.4
TOTAL	$7.9

Temporary adjustments which can be taken at this time to partially meet the projected deficit are expedients that would enable the Department to end the fiscal year in a balanced position. These are:

	Net County Cost ($ in Millions)
-- Employee leaves without pay	$ 5.5
-- Deferred purchase of supplies and equipment until 1982-83	8.1
TOTAL	$13.6

All of the combined actions shown above, as well as the $14.3 million in additional State aid, will be sufficient measures to enable the Department to end the fiscal year with a balanced budget. However, the majority of these are one-time measures which will not be available to finance the 1982-83 budget.

Hearing Issues

We are recommending that you conduct Beilenson Hearings for the purpose of identifying permanent program reductions which can be implemented during the current fiscal year and be in place for the beginning of the 1982-83 fiscal year. This action will enable you to deal with the following questions:

1. Should annualized program reductions in the amount of $13.6 million be ordered in January to recognize that the savings resulting from employee leaves of absence and deferment of supply and equipment purchases are one-time resources only?

2. Should annualized program reductions of $11.8 million be ordered to recognize the one-time nature of State aid received in the current year from Berman and Statham funds?

3. Should additional program reductions be ordered in January to reflect our analysis (to be submitted on January 26, 1982) of the County-wide financial condition and the Governor's budget or additional Federal budget actions which may adversely impact County Health Services financing? This will also include any current year reductions in State subventions which may be identified in the Governor's Budget to deal with the State's projected deficit for the current year.

The Director of Health Services and I are advising that these Hearings be conducted in order to prepare the Board to deal with potential State and Federal funding short-falls for 1982-83 in a manner which will permanently reduce the level of spending for County Health Services.

Detailed Attachments

The following documents are attached for use during the Beilenson Hearings:

Attachment		Document
A		Detail of Expenditure Reductions and Available Revenues Totaling $35.8 Million
B		Items included in Original Notice:
	1.	Department of Health Services Non-Beilenson Programs (Subsequent to the posting of Notices, County Counsel advised that these Programs are not subject to the Beilenson process.)
	2.	Department of Health Services Proposed Beilenson Modifications
C		Proposed Agenda for the Beilenson Hearings
D		Recommended Budget Adjustment

Report on County-Wide Financial Condition and Governor's Budget

This financial report to be presented to you on January 26, 1982, will provide the Board with the projections and recommendations which will enable you to deal with the health services financing situation while having all the available facts before you. This will include:

-- 1981-82 full year spending and revenue estimates including necessary appropriation adjustments to complete the fiscal year in a balanced position.

-- Preliminary analysis of the 1982-83 Governor's budget and its potential impact on County programs.

-- Recommended policy foundation for development of the 1982-83 County budget.

-- Further analysis of the impact of Federal Budget reductions as available.

THEREFORE, WITH THE CONCURRENCE OF COUNTY COUNSEL, IT IS RECOMMENDED THAT YOUR BOARD:

1. Approve the following actions:

    a. Adopt the attached budget adjustment (Attachment D) which will appropriate the State Berman Funds, Statham Funds, and additional alcohol fund allocation.

    b. Instruct the Director of Health Services to maintain the selective hiring freeze.

    c. Instruct the Director of Health Services to implement the more effective use of resources (listed on Attachment A) and to take actions ensuring the achievement of additional revenues in the Comprehensive Health Centers.

    d. Instruct the Director of Health Services to take necessary steps to implement the employee leave without pay proposal and defer purchase of supplies and equipment as outlined above.

2. Proceed with the December 15 scheduled Beilenson Hearings by adopting the attached agenda for conduct of the Hearings and by accepting all oral and written testimony presented at the Hearings. In addition, accept all written testimony up to the close of business on December 31.

3. Instruct the County Counsel, with the assistance of Health Services and the Chief Administrative Office, to prepare appropriate findings, based upon evidence presented, and present these recommended findings on January 26, 1982.

4. Instruct the Chief Administrative Office to report on the total County financial picture on January 26, 1982.

Very truly yours,

Harry L. Hufford

HARRY L. HUFFORD
Chief Administrative Officer

Robert W White

ROBERT W. WHITE, Director
Department of Health Services

HLH:RWW
RBD:ea
2:h
Attachments
cc: Executive Officer
  Board of Supervisors
  Auditor-Controller

Attachment A

HEALTH SERVICES
DETAIL OF EXPENDITURE REDUCTIONS AND AVAILABLE REVENUE

	Continuing Funding	One Time Funding	Total
-- **Maintain Selective Hiring Freeze** Only critical positions will continue to be filled (e.g., direct patient care and revenue positions).	$ 4.0	--	$4.0
-- **Enhance Revenue Collection** The Department has reviewed the cash collection for services and Medi-Cal collections at the Comprehensive Health Centers and determined that increased efforts in this area can generate an additional $1.5 million without additional resources.	$ 1.5	--	$1.5
-- **Appropriate the Additional Financing Resulting from Recent Legislation** The State legislature has passed, and the Governor has signed into law, AB 1540 (Berman), which has added additional funding to the State AB 8 subsidy for local health care (results in an additional $10.5 million for Los Angeles County) and AB 2086 (Statham) and final allocation of State alcohol funds, which provide additional funding for alcohol programs (results in an additional $3.8 million for Los Angeles County).			
- Berman Funds	$ --	$10.5	$10.5
- Statham and Other Alcohol Allocations	2.5	1.3	3.8
SUBTOTAL	$ 2.5	$11.8	$14.3

	Continuing Funding	One-Time Funding	Total
-- More Effective Use of Resources			
The Department has identified other areas where, through more effective use of departmental resources, savings can be realized. These savings will not impact patient care.			
-- Utilities (energy/conservation)	$ 1.1	--	$ 1.1
-- Dietary (employee cafeteria)	.5	--	.5
-- Trailers (leases of equipment)	.4	--	.4
-- Communication	.2	--	.2
-- Interpreters	.1	--	.1
-- Word Processors	.1	--	.1
SUBTOTAL	$ 2.4	--	$ 2.4
-- Institute an Employee Work Furlough Program	--	$ 5.5	$ 5.5
Employees will be instructed to take one day per month off without pay.			
-- Administrative Freeze on Supplies and and Equipment Expenditures	--	$ 8.1	$ 8.1
This is a one-time depletion of inventories and postponement of supplies and fixed assets purchases.			
TOTAL	$10.4	$25.4	$35.8

/ea
10:b

Attachment B-1

POTENTIAL DEPARTMENT OF HEALTH SERVICES
PROGRAM MODIFICATIONS NOT SUBJECT TO BEILENSON

Program	Potential Annualized Program Reductions	Explanation
Alcohol and Drug Abuse Programs	$21, 274,855	These programs provide a variety of substance abuse prevention, treatment and/or information programs to persons throughout the County. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. These programs do not include basic medical services that are not otherwise available in the County health system.
Immunization	422,494	This program enhances immunizations (i.e, influenza, diphtheria, tetanus, measles, mumps, etc.) to the County population as a whole. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a public health program and does not include basic medical services that are not otherwise available in the County health system.
Tuberculosis testing and T.B. Chemoprophylaxis	424,040	This program enhances diagnostic evaluation for tuberculosis and medical prevention therapy to the County population as a whole. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a public health program and does not include basic medical services that are not otherwise available in the County health system.
Venereal Disease Control/ Testing	1,715,000	This program enhances diagnosis, treatment and case investigation for venereal disease to the County population as a whole. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a public health

Program	Potential Annualized Program Reductions	Explanation
		program and does not include basic medical services that are not otherwise available in the County system.
Family Planning	$ 2,569,362	This program enhances basic contraceptive services, medical, sterilization and pregnancy testing to low income families. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a social and public health program and does not include basic medical services that are not otherwise available in the County health system.
Prenatal Services	188,287	This program enhances physical examinations, laboratory testing, and other health supervision services for prenatal patients, including high risk patients without regard to income. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a public health and educational program and does not include basic medical services that are not otherwise available in the County health system.
Child Abuse Study	23,179	This program provides educational services to aid physicians and others in recognizing Child Abuse. This program does not provide direct medical services to the population. This program is an educational program.
Community Health Centers	520,000	This program enhances the delivery of primary health care services to the population served at Roybal and Hudson Comprehensive Health Centers. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods.

Program	Potential Annualized Program Reductions	Explanation
Maternal & Child Health	$ 1,890,000	This program enhances existing services for genetic disease testing and counseling, hemophilia diagnosis and treatment, sudden infant death syndrome and lead-based paint poison screening to the population as a whole. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a public health and educational program and does not include basic medical services that are not otherwise available in the County health system.
Maternal & Infant Care	1,400,000	This program enhances diagnostic and treatment services to reduce infant mortality and to promote maternal and child health to the population as a whole. A program modification could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a public health program and does not include basic medical services that are not otherwise available in the County health system.
Child Health Disability Prevention (CHDP & EPSDT)	2,391,404	This program enhances screening services for disabling diseases in children of low income families. These services include physical examination, laboratory testing, hearing and eye tests, immunization and problem referrals. Reductions or elimination of this program could result in diversion of clientele to other County and/or private health providers with potentially greater travel distances and waiting periods. This program is primarily a public health program and does not include basic medical services that are not otherwise available in the County health system.
ommunicable Disease ontrol Indo-Chinese efugee Assistance rogram (CDC-IRAP)	194,000	This program enhances screening services for tuberculosis in the Indo-Chinese refugee population. These services include physician examination, laboratory testing and follow-

Program	Potential Annualized Program Reductions	Explanation
		up. Reduction or elimination of this program could result in the shift of clientele to other County and/or private health facilities with potentially greater travel distances and waiting periods. This program is primarily a public health program and does not include basic medical services that are not otherwise available in the County health system.
Public Health Center Consolidation	$ 500,000	The present geographic distribution of health centers enhances the availability of public health services. Closures of these health centers would result in the consolidation of services into other existing centers with no reduction in services but only a decrease in geographic accessibility. Public health services would continue to be available within a five-mile radius of any County resident with few exceptions. These centers provide public health services and do not include basic medical services that are not otherwise available in the County health system.
Administration	Proportionate	The Department of Health Services will consider additional administrative reductions.
TOTAL	$ 33,512,621	

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ATTACHMENT B-2

DEPARTMENT OF HEALTH SERVICES PROPOSED BEILENSON MODIFICATIONS

	Approp. Reduction
LAC/USC/MC	
Walk-in Clinic	980,727
Outpatient Services	2,669,829
Lab Services	250,000
Reduction in Intern Housestaff	600,000
Peds. Bed Reduction	1,786,783
Renal Dialysis	907,490
Rehab. Med.	136,000
Audiology Svcs.	87,000
Home Care Program	712,000
Subtotal	$ 8,129,829
Harbor-UCLA Medical Center	
Physical Therapy	$ 168,979
Occ. Therapy	255,069
Comm. Disorders	99,351
Otpt. Clinics	2,087,875
Med./Surg.Clinics	196,538
Subtotal	$ 2,807,812
Martin Luther King, Jr., General Hospital	
Family Medicine	$ 792,172
Occ. Therapy	223,185
Medical Clinic	99,147
Surgical Clinic	99,147
Phys. Therapy	177,579
Bed Reduction	1 434,457
Subtotal	$ 2,825,687
Rancho Los Amigos Hospital	
O.P.D. Central Supplies	$ 176,077
O.P.D. Equipment	234,770
Orthotics	821,693
Pharmacy	616,725
Casa Consuelo	286,896
Subtotal	$ 2,136,161
Olive View Medical Center	
Primary Care Clinic	$ 292,591
Specialty Care Clinic	220,000
Otpt. Lab Svcs.	250,000
Otpt. Radiology Svcs.	150,000
Occ. Therapy Svcs.	59,000
Otpt. Pharmacy Svcs.	43,000
Subtotal	$ 1,014,591
Long Beach General Hospital	
Otpt. Dental Svc.	$ 123,435
Otpt. Pediatric Svcs.	122,681
	$ 246,116

Mira Loma Hospital	
Surgery	$ 69,076
Otpt. Pharmacy	254,525
Skilled Nursing Beds	78,671
Subtotal	$ 402,272
Subtotal Hospitals	$ 17,562,468
Ambulatory Care/CHCs	
Roybal	$ 5,987,640
Humphrey	7,367,700
Hudson	7,539,900
East L.A. C. & Y. Clinic	3,704,760
Subtotal	$ 24,600,000
Amb.Care/Hlth.Ctrs.	4,900,000
Subtotal Ambulatory Care	$ 29,500,000
Grand Total	$ 47,062,468

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12/9-81

Program	Gross Approp.	Changes to Existing Health Facilities and Services
LAC/USC Medical Center	$ 8,129,829*	
Walk-In Clinic	$ 980;727	A 55% reduction of the Walk-In Clinic services will limit the provision of medical services for those patients who arrive without appointments. Commensurate reductions in ancillary and technical services which provide support for this area's activity will also occur.
Outpatient Services	$ 2,669,829	The Outpatient Department services will be curtailed by 20 percent.
Lab Services	$ 250,000	Less time critical laboratory tests normally contracted out will be performed on-site or eliminated wherever possible. This may result in some disruption in the continuity of medical services provided to the patients.
Reduction in Intern Housestaff	$ 600,000	A 10% reduction in intern housestaff will reduce the ratio of housestaff to patients. This reduction could result in direct patient care services being delivered in a less timely manner.

*Identified curtailments include commensurate administrative reductions.

Program	Gross Approp.	Changes to Existing Health Facilities and Services
Pediatric Bed Reduction	$ 1,786,783	Consolidation of support services and the utilization of community resources during the high peak season will allow the elimination of 20 inpatient beds.
Renal Dialysis	$ 907,490	All outpatient non-acute renal dialysis services will be eliminated.
Rehabilitation Medicine	$ 136,000	The change proposed in the Rehabilitation Medicine Department is the elimination of the Physiatrists. These physicians currently serve in a consultative role for all medical and surgical services at the Medical Center.

Program	Gross Approp.	Changes to Existing Health Facilities and Services
Audiology Services	$ 87,000	The Audiology Service at LAC/USC Medical Center is a non-mandated service that provides diagnostic and consultation services to all medical divisions at the Medical Center. This service will be reduced ninety percent (90%) leaving only minimal resources available. These resources will be assigned to critical inpatient services.
Home Care Program	$ 712,000	Currently, the Home Care Program provides medical and nursing services to bed-bound patients as an alternative to hospitalization. The proposed curtailment would eliminate this program. Home care services include occupational therapy, physical therapy, respiratory therapy and skilled nursing services. There are presently 300 patients enrolled in this program representing 700 visits a month.

rogram	Gross Approp.	Changes to Existing Health Facilities and Services
arbor-UCLA Medical Center	$ 2,807,812*	
hysical Medicine		The proposed curtailments identified for Physical Therapy and Occupational Therapy will eliminate Harbor-UCLA's ability to provide rehabilitation services, measuring and fitting of appliances, teaching of patients on how to use medical appliances and personal management.
-Physical Therapy	$ 168,979	
-Occupational Therapy	$ 255,069	
Communication Disorders	$ 99,351	Speech Pathology & Audiology services will be reduced by approximately 70%. The greatest impact is expected to be in cases where surgery is needed to correct a hearing defect and treatment is delayed because the patient has not received the proper testing.
Outpatient Clinics	$ 2,087,875	Harbor will reduce outpatient clinic visits by 16.5% or 32,000 patient visits per year. Impacted will be Eye, ENT, Ortho/Cast Room, OB/GYN, Peds, Urology, etc.

*Identified curtailments include commensurate administrative reductions.

S2/4-1

Program	Gross Approp.	Changes to Existing Health Facilities and Services
Harbor-UCLA Medical Center		
Medical/Surgical Clinics	$ 196,538	Medical/Surgical clinics will be reduced approximately 3.2% or by 2,870 patient visits per year. Impacted sub-clinics will include Minor Trauma, Plastic Surgery, Sports Medicine, Foot and Hand, Spine and Scoliosis, some Peds Clinics, e.g., Parasitology, Failure to Thrive, etc. Longer waiting times for direct care by a physician will delay appropriate diagnostic tests, radiology and lab work.

Program	Gross Approp.	Changes to Existing Health Facilities and Services
Martin L. King, Jr., Gen. Hosp.	$ 2,825,687*	
Family Medicine	$ 792,172	The Family Medicine Department provides comprehensive care for the overall family groups. The service was developed to extend knowledge to the community of group health care and to meet the long range goal of increasing the number of primary physicians trained who provide care within the community. The staff of Family Medicine provides physician services to inpatient and outpatient clinics and wards within the acute hospital. This program will be curtailed by 75%.
Occupational Therapy	$ 223,185	The Occupational Therapy Outpatient Program provides rehabilitative services for patients who have been treated on an acute basis and are ready for discharge, but require long-term outpatient services designed to allow the patient to function at home. Within this proposed curtailment the Occupational Therapy Outpatient Program is scheduled for a 53% reduction in the level of service.

*Identified curtailments include commensurate administrative reductions.

52/5-1

rogram	Gross Approp.	Changes to Existing Health Facilities and Services
edical Clinic	$ 99,147	The Medical Clinic, which will be reduced by 15%, provides comprehensive services to the Southeast area. In addition, the Medical Clinic performs the Walk-In Clinic function.
Surgical Clinic	$ 99,147	The Surgical Clinic provides follow-up care to approximately 1800 patients per month. Many are receiving follow-up treatment as a result of surgery performed at MLK. The curtailment will reduce the level of service by less than 5%. The initial follow-up will continue to be provided. Subsequent follow-up may be required to be performed through private practitioners.
Physical Therapy	$ 177,579	Currently MLK is experiencing an average of 40-50 outpatient visits a day in Physical Therapy. This service will be reduced by 27%.

Program	Gross Approp.	Changes to Existing Health Facilities and Services
Martin L. King, Jr., Gen. Hosp.		
Reduction of Inpatient Beds	$ 1,434,457	The reduction of 6 inpatient beds; two Gynecology, two Medicine, two Pediatrics, will reduce the number of available budgeted beds to 294. The hospital currently operates at 94% of its available budgeted beds. The reduction will result in operating at 100% of the remaining budgeted beds. This reduction will restrict the hospital's ability to respond to overflow situations.

52/5-3

Program	Gross Approp.	Changes to Existing Health Facilities and Services
Rancho Los Amigos Hospital	$ 2,136,161*	
Outpatient Central Supplies	$ 176,077	Patients currently receive some supplies from Central Services after a clinic visit as an extension of hospital care at home. The dispensing of central service supplies including such items as cotton balls, unsterile gloves, bandages, catheters, etc., will be reduced by 95%.
Patient Equipment	$ 234,770	At the time of discharge or after a clinic visit, if the liaison nurses determine that a patient requires equipment, (such as patient lifts, beds, etc.) it is ordered and delivered to the patient. By reducing this service, over 98% of the patients currently receiving this service will be referred to the private sector.
Orthotics	$ 821,693	The dispensing of orthotic devices to patients with third party coverage will be discontinued.

*Identified curtailments include commensurate administrative reductions.
52/6-1

rogram	Gross Approp.	Changes to Existing Health Facilities and Services
harmacy	$ 616,725	There will be a 75% reduction in outpatient Pharmacy Services. This reduction will result in 150,000 fewer prescriptions being filled.
Casa Consuelo	$ 286,896	Last year, Casa Consuelo Vocational Residence, a 21 bed residential program, served over one hundred Rancho patients. Typically, these patients have sustained an injury which prevented them from obtaining gainful employment and independent living. Casa provides these patients with an opportunity to participate in a structured vocational rehabilitation program while living in a sheltered setting. Casa also provides these patients with evaluation and instruction in the "independent living skills" needed to function independently in the community.

rogram	Gross Approp.	Changes to Existing Health Facilities and Services
live View Medical Center	$ 1,014,591*	
rimary Care Clinics	$ 292,591	There will be a 4% reduction of outpatient care in the Primary Clinics. This will impact approximately 2706 patient visits.
pecialty Care Clinics	$ 220,000	There will be a 4% reduction of Outpatient Specialty Care Clinics. Approximately 2035 patient visits will be affected.
Outpatient Lab Services	$ 250,000	There will be a 9.8% reduction of services in the Outpatient Lab. Approximately 380,000 Relative Value Units of lab tests will be affected. (Approximataly 168,000 tests.)
Outpatient Radiology Services	$ 150,000	There will be a reduction of 7.6% in Outpatient Radiology. Approximately 12,560 Relative Value Units of service will be affected (3150 procedures).
Occupational Therapy Services	$ 59,000	There will be a 14% reduction of service in Occupational Therapy. Approximately 8600 Relative Value

*Identified curtailments include commensurate administrative reductions.
52/7-1

rogram	Gross Approp.	Changes to Existing Health Facilities and Services Units of service will be affected.
utpatient Pharmacy Services	$ 43,000	There will be a general reduction of Outpatient Pharmacy services of approximately 5%. This will result in 1700 fewer prescriptions to be filled annually.

Program	Gross Approp.	Changes to Existing Health Facilities and Services
LONG BEACH GENERAL HOSPITAL	$ 246,116*	
Outpatient Dental Service	$ 123,435	The Outpatient Dental Service that provides service for persons 14 years of age or older will be eliminated. An average of approximately 200 patients are treated monthly.
Outpatient Pediatric Services	$ 122,681	The Outpatient Pediatric Service will be eliminated, affecting approximately 125 patient visits monthly.

* Identified curtailments include commensurate administrative reductions.

ogram	Gross Approp.	Changes to Existing Health Facilities and Services
ra Loma Hospital	$ 402,272*	
urgery	$ 69,076	Postponement of approximately 5% in outpatient surgical procedures and Outpatient Surgical Clinic visits.
utpatient Pharmacy	$ - 254,525	The Outpatient Pharmacy services will be discontinued.
Skilled Nursing Beds	$ 78,671	Decrease Skilled Nursing Facility beds from 70 to 64
Subtotal Hospitals	$ 17,562,468	

*Identified curtailments include commensurate administrative reductions.
52/11-1

Program	Gross Approp.	Changes to Existing Health Facilities and Services
Ambulatory Care/CHC	$ 24,600,000*	Comprehensive Health Centers
	$ 5,987,640	Edward R. Roybal - Elimination of all Ambulatory & Dental Care Services.
	$ 7,367,700	H.H. Humphrey - Elimination of all Ambulatory & Dental Care Services.
	$ 7,539,900	H.Claude Hudson - Elimination of all Ambulatory & Dental Care Services.
	$ 3,704,760**	E.L.A. C. & Y. Clinic - Elimination of all Ambulatory & Dental Care Services.
		The elimination of the Ambulatory primary and secondary care services includes specialty medical clinics, dental hygiene and outpatient surgery, as well as ancillary support services.
		With the elimination of services, the balance of the activities at the Comprehensive Health Centers remaining in operation will be those activities dealing with Public Health. This may require the closure of 1-2 Comp. Health Centers and the consolidation of Public Health Services at the remaining facilities.
Ambulatory Care/Health Centers	$ 4,900,000*	Community Health Centers - The Ambulatory Care component provided within local health centers will be eliminated.

*Identified curtailments include commensurate administrative reductions.

**This amount includes the following Public Health components: $1,890,000 Maternal & Child Health and $900,000 Maternal & Infant Care.

52/8-1

Program	Gross Approp.	Changes to Existing Health Facilities and Services
		Although the Ambulatory Care services are being eliminated, the Public Health activities will continue to be provided.
Subtotal Ambulatory Care	$ 29,500,000	
Grand Total	$ 47,062,468	

Attachment C

PROPOSED AGENDA
BEILENSON HEARINGS OF DECEMBER 15, 1981

I. Open Beilenson Hearings on December 15, 1981.

-- Comments by Chief Administrative Officer.

-- Remarks by Chairman of the Board and other Board members.

-- Presentation by Director of Health Services.

II. Receive testimony (written and oral) from members of the public and/or other interested parties.

-- List of speakers scheduled by the Executive Office

III. At conclusion of the public hearing, MOVE that the BOARD:

-- Instruct the Executive Officer to keep open the hearings to permit additional written testimony to be filed through the close of business, Thursday, December 31, 1981

-- Instruct the Executive Officer to distribute all material received, which has been filed, to each member of the Board, the Chief Administrative Officer, County Counsel, and the Director of Health Services.

-- Instruct the County Counsel, with the assistance of the Chief Administrative Officer and Director of Health Services, to prepare and submit to the Board recommended findings based upon testimony and written reports received during the current Beilenson Hearings.

IV. Upon receipt of these recommended findings from the Chief Administrative Officer:

-- Adopt appropriate findings with any modifications the Board may order.

-- Instruct the Director of Health Services to implement the required program changes based upon the recommended findings, as modified by the Board, at the end of a 60-day State notification period.

-- Instruct the Director of Health Services to prepare the State plan and submit to the State Department of Health Services upon adoption of findings.

12/9/81

Attachment D

RECOMMENDED BUDGET ADJUSTMENTS

Board of Supervisors Official

COUNTY OF LOS ANGELES

REQUEST FOR APPROPRIATION ADJUSTMENT

Dept. No. Page 1

DEPARTMENT OF Health Services December 10, 1981

AUDITOR-CONTROLLER

THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION OR ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

TRANSFER FROM
GENERAL FUND

20400 Alcohol & Drug Abuse
Anticipated Revenue
8409 Statham $ 757,950
8771 State Other $ 3,042,050
$ 3,800,000

5502 Other Charges 463,119

19600 Central Region
Anticipated Revenue
8770 Other State
Aid - Health $ 2,951,81

19750 Coastal Region
Anticipated Revenue
8770 Other State
Aid - Health $ 150,000

20650 San Fernando Region
Anticipated Revenue
8770 Other State
Aid - Health $ 250,000

TRANSFER TO

20400 Alcohol & Drug Abuse
1002 Salaries $ 546,
2002 Services & Supplies $ 3,716,
$ 4,263,

19600 Central Region
1002 Salaries $ 2,951,

19750 Coastal Region
1002 Salaries $ 150,

20605 San Fernando Region
1002 Salaries $ 250,

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR ACTION

RECOMMENDATION

AUDITOR-CONTROLLER BY

APPROVED AS REQUESTED AS REVISED

19

CHIEF ADMINISTRATIVE O

APPROVED (AS REVISED): BOARD OF SUPERVISORS 1

BOARD O
SUPERVI
OFFICIAL

COUNTY OF LOS ANGELES

REQUEST FOR APPROPRIATION ADJUSTMENT

DEPT'S NO. Page 2

DEPARTMENT OF Health Services December 10, 19

AUDITOR-CONTROLLER:
THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATIC ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

GENERAL FUND (Cont'd)

20750	San Gabriel Region Anticipated Revenue 8770 Other State Aid - Health	$ 600,000	20750	San Gabriel Region 1002 Salaries	$ 60
20900	Southeast Region Anticipated Revenue 8770 Other State Aid - Health	$ 2,000,000	20900	Southeast Region 1002 Salaries	$ 2,00
		$10,214,934			$10,21

ENTERPRISE FUND

60700	Long Beach General Hosp. Anticipated Revenue 8770 Other State Aid Health	$ 3,500,000	60700	Long Beach General Hosp. 1002 Salaries 2002 Services & Supplies	$ 3,000 500
63250	Rancho Los Amigos Anticipated Revenue 8870 Other State Aid - Health	$ 1,000,000	63250	Rancho Los Amigos 1002 Salaries	$ 1,000

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR— ______ ACTION

______ RECOMMENDATION

AUDITOR-CONTROLLER BY ______

NO. ______ ______ 19

APPROVED AS REQUESTED ______ AS REVISED ______

______ 19 ______

CHIEF ADMINISTRATIVE OFFICER

APPROVED (AS REVISED): BOARD OF SUPERVISORS ______ 19

BY

Board of
Supervisors
Official Cop

COUNTY OF LOS ANGELES

REQUEST FOR APPROPRIATION ADJUSTMENT

Dept. No. Page 3

DEPARTMENT OF December 10, 1981

AUDITOR-CONTROLLER.
THE FOLLOWING APPROPRIATION ADJUSTMENT IS DEEMED NECESSARY BY THIS DEPARTMENT. WILL YOU PLEASE REPORT AS ACCOUNTING AND AVAILABLE BALANCES AND FORWARD TO THE CHIEF ADMINISTRATIVE OFFICER FOR HIS RECOMMENDATION ACTION.

ADJUSTMENT REQUESTED AND REASONS THEREFOR

The purpose of this budget adjustment is to recognize changes in State subvention funding, increased revenue available through Berman (AB1540), Statham (AB2086), and other alcohol program allocation. This action will not affect Net County Cost.

CHIEF ADMINISTRATIVE OFFICER'S REPORT

REFERRED TO THE CHIEF ADMINISTRATIVE OFFICER FOR— ACTION

RECOMMENDATION

APPROVED AS REQUESTED ✓ AS REVISE

12 Dec 19 81

CHIEF ADMINISTRAT

Health Care Cuts!

THE BOARD OF SUPERVISORS HAS REDUCED FUNDS FOR COUNTY HEALTH CARE BY $56 MILLION DOLLARS.

That cut will mean that the following services will be reduced or will be totally eliminated:

ACROSS THE BOARD BUDGET CUTS IN ALL COUNTY HOSPITALS

The budgets of all county hospitals reduced by 10%.

CLOSE THE FOLLOWING 8 HEALTH CLINICS

Santa Fe Springs
Norwalk
Culver City
North Enterprise
Villa Carson
Bell Gardens
Dollarhide
Pacoima

ELIMINATE ALL AMBULATORY ("walk-in") CARE AT 32 CLINICS

Bellflower
Hawiian Gardens
Imperial Heights
Baldwin Park
Paramount
Monrovia
Pico Rivera
Florence-Firestone
Burbank
Harbor-San Pedro
Wilmington
Montebello
Lawndale
Alhambra
Avalon
Azusa
Central
East Valley
Hollywood-Wilshire
Inglewood
La Puente
Northeast
San Antonio
South
Southwest
Torrance
Tujunga
Valencia
Van Nuys
Venice
West Hollywood
Whittier

These clinics served some 460,000 patients last year. These "walk-in" patients will now have to travel to more distant and much more crowded clinics to get medical care

ELIMINATE ALL OUTPATIENT PHARMACY SERVICES

Hospitals and clinics will no longer fill any prescriptions for outpatients. This includes prescriptions for patients discharged from hospitals. Last year these hospitals and clinics filled 1.5 million prescriptions.

ELIMINATE ALL MEDICAL SOCIAL WORKERS AND PROGRAMS

Child Abuse Referral Team
Sudden Infant Death Syndrome Counseling
Battered Women Counseling & Referral
Wife Abuse Probationer Counseling
Premature Infant Counseling
Emergency Family Aid Referral
Family Counseling Program
Adult Therapy Counseling

These programs served about 25% of the comprhensive health center patients

ELIMINATE ALL HEALTH EDUCATION PROGRAMS

These programs do not always deal with immediate health care but are most important in long term health. They educate people about diseases and provide immunization services that prevent the spread of many diseases. Last year these programs generated 18,400 patient contacts. That could mean that almost 19,000 people will be spreading diseases that could have been prevented in the first place. The following kinds of programs will be eliminated:

Health Information & Coordination

Health Information Outreach

Immunization Clinics

Screening Clinics

Health Fairs

ELIMINATE ALL NUTRITIONIST PROGRAMS

These programs will be missed by 16% of the current patient workload. In the last year 15,300 patients encounters were made in the nutrition area. Since many diseases are the result of or are complicated by poor nutrition, loss of these programs will increase medical problems for people with diseases such as diabetes and high blood pressure. The nursing staff, already 30% short of people, will have to try to perform these duties.

GREATLY REDUCE THE PATIENT TRANSPORTATION SERVICE (PTS)

Reduce the PTS staff by 77% (127 employees will be reassigned or fired). This means that the county will have to:

Discontinue transportation of patients from private hospitals & nursing homes to County hospitals,

--and--

Discontinue transporting outpatients to County hospitals.

THESE ARE THE MOST SERIOUS CUTS IN COUNTY HEALTH CARE. THERE ARE MORE!

PUBLIC FORUMS ON COUNTY HEALTH CARE CUTS!!!!

There are 2 forums scheduled in the first week of August and there will be others later in the month.

1. Thursday, August 6th. 1:00--4:00 in the afternoon.
   543 N. Fairfax Ave. Los Angeles (National Council of Jewish Women Bldg.)

2. Saturday, August 8th. 11:00 A.M.--2:00 in the afternoon.
   5850 So. Main St. Los Angeles (Hubert Humphrey Comprehensive Health Center

These forums are endorsed or sponsored by:
Assemblywoman Maxine Waters
Congressman Julian Dixon
Assemblyman Mel Levine
Senator Diane Watson
Senator Alan Sieroty
County Health Alliance
Coalition for Economic Survival(CES)
Californians for a Full Cost of Living

Other forums in East Los Angeles and the San Fernando Valley are now being planned.

FIRST SUPERVISORIAL DISTRICT

Pete Schabarum, Supervisor
974-1011

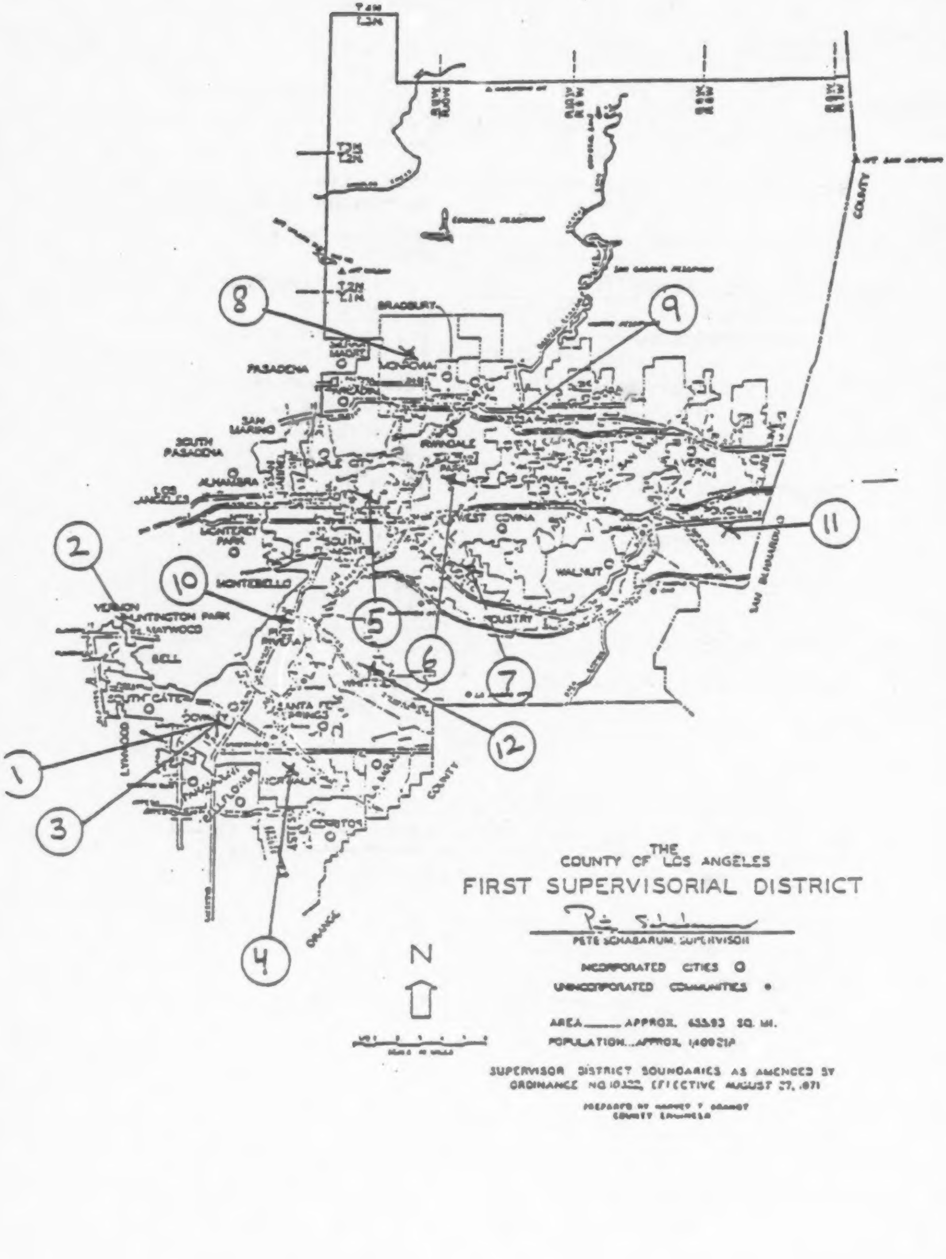
HEALTH CARE FACILITIES

	Name of facility	Address
1.	Rancho Los Amigos Hospital (***) (****)	7601 E. Imperial Highway Downey
2.	San Antonio Health Center (**)	6538 Miles Ave. Huntington Park
3.	Downey Sub-Center	10924 La Reina St Downey
4.	Norwalk Sub-Center (*)	12360 E. Firestone Bl. Norwalk
5.	El Monte Health Center	3550 N. Eastmont El Monte
6.	Baldwin Park Sub-Center (**)	4640 N. Maine Ave. Baldwin Park
7.	La Puente Health Center (**)	15930 Central Ave. La Puente
8.	Monrovia Health Center (**)	330 W. Maple Ave. Monrovia
9.	Azusa Sub-Center (**)	150 N. Azusa Ave. Azusa
10.	Pico Rivera Health Center (**)	6336 S. Passons Bl. Pico Rivera
11.	Pomona Health Center	750 S. Park Ave. Pomona
12.	Whittier Health Center (**)	7643 S. Painter Ave. Whittier

The following services have been eliminated at all of the facilities listed above: Outpatient Pharmacy, Medical Social Workers, Nutritionists, and Health Education.

The following services, marked with asterisks(*****), have been eliminated or seriously reduced.

* CLOSED
** Eliminate Ambulatory Care (Walk-in service)
*** Eliminate Renal Dialysis
**** Reduce or eliminate Dental Service


THE
COUNTY OF LOS ANGELES
FIRST SUPERVISORIAL DISTRICT
PETE SCHABARUM, SUPERVISOR
INCORPORATED CITIES ○
UNINCORPORATED COMMUNITIES ●
AREA _____ APPROX. 633.93 SQ. MI.
POPULATION...APPROX. 1,400,219
SUPERVISOR DISTRICT BOUNDARIES AS AMENDED BY
ORDINANCE NO 10,222, EFFECTIVE AUGUST 27, 1971
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COUNTY
ORANGE
SAN BERNARDINO
BRADBURY
MONROVIA
PASADENA
SAN MARINO
SOUTH PASADENA
ALHAMBRA
LOS ANGELES
MONTEREY PARK
MONTEBELLO
VERNON
HUNTINGTON PARK
BELL
SOUTH GATE
LYNWOOD
DOWNEY
SANTA FE SPRINGS
NORWALK
CERRITOS
WEST COVINA
COVINA
WALNUT
INDUSTRY
IRWINDALE
EL MONTE
SOUTH EL MONTE
LA VERNE
SAN GABRIEL RESERVOIR
COGSWELL RESERVOIR

SECOND SUPERVISORIAL DISTRICT

Kenneth Hahn, Supervisor
974-2222

HEALTH CARE FACILITIES

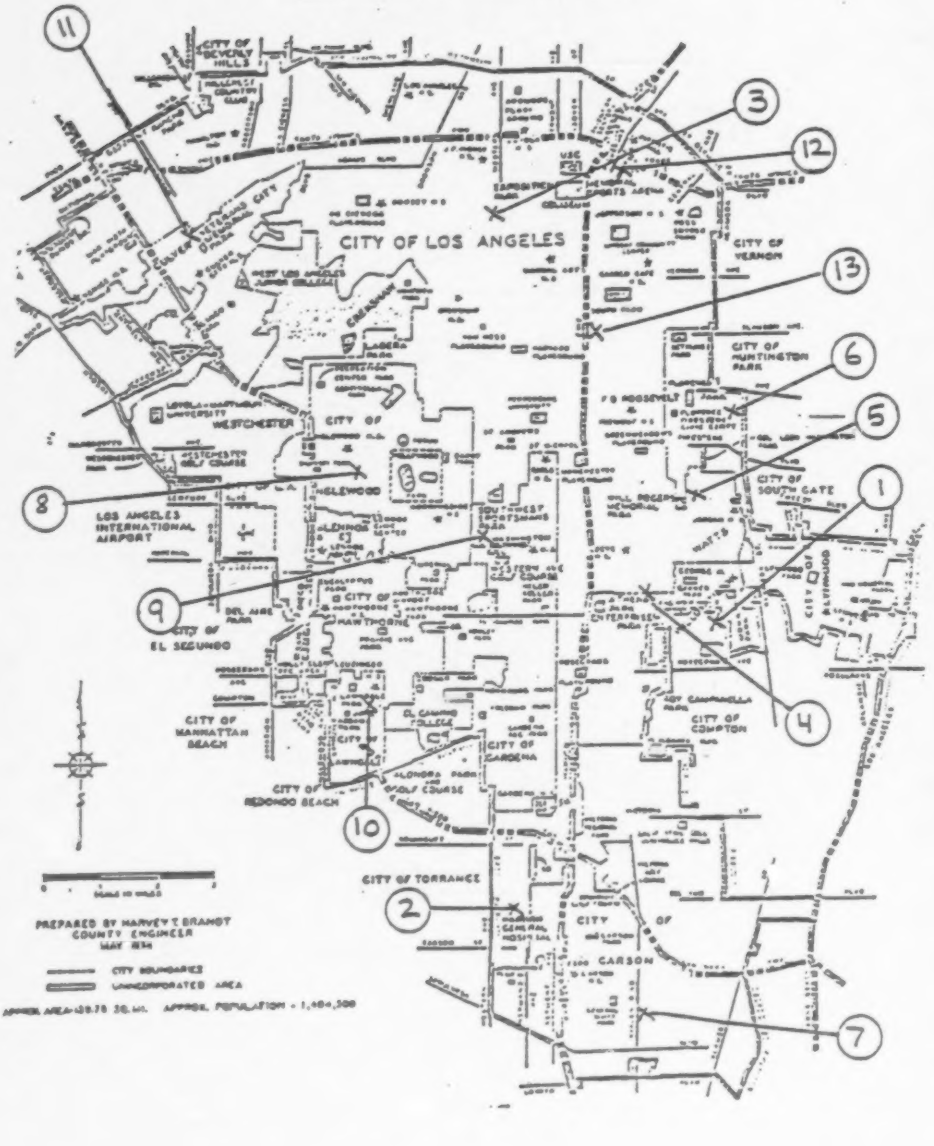
	Name of facility	Address
1.	Martin Luther King, Jr (***) Hosptial (****)	12021 Wilmington Ave. Los Angeles
2.	Harbor/UCLA Medical Center (***) (****)	1000 W. Carson St. Torrance
3.	Southwest Health Center (**)	3834 S. Western Ave Los Angeles
4.	North Enterprise Sub-Center (*)	638 E. El Segundo Bl. Los Angeles
5.	South Health Center (**)	1522 E. 102nd St. Los Angeles
6.	Florence/Firestone Sub-Center (**)	8019 Compton Ave. Los Angeles
7.	Villa Carson Sub-Center (*)	23233 S. Avalon Bl. Wilmington
8.	Inglewood Health Center (**)	123 W. Manchester Bl. Inglewood
9.	Imperial Heights Sub-Center (**)	10616 S. Western Ave. Los Angeles
10.	Lawndale Sub-Center (**)	14616 S. Grevillea Ave. Lawndale
11.	Culver City Sub-Center(*)	4150 Overland Ave. Culver City
12.	H. Claude Hudson (****) Comprehensive Health Center	2847 S. Grand Ave. Los Angeles
13.	Hubert H. Humphrey (****) Comprehensive Health Center	5850 S. Main Los Angeles

The following services have been eliminated at all of the facilities listed above: Outpatient Pharmacy, Medical Social Workers, Nutritionists, and Health Education.

The following services, marked with asterisks(*****), have been eliminated or seriously reduced.

* CLOSED
** Eliminate Ambulatory Care (Walk-in service)
*** Eliminate Renal Dialysis
**** Reduce or eliminate Dental Service

SECOND SUPERVISORIAL DISTRICT
OF THE COUNTY OF LOS ANGELES
KENNETH HAHN ---------------- SUPERVISOR



PREPARED BY HARVEY T. BRANDT
COUNTY ENGINEER
MAY 1974

CITY BOUNDARIES
UNINCORPORATED AREA

APPROX. AREA - 139.78 SQ. MI. APPROX. POPULATION - 1,404,300

THIRD SUPERVISORIAL DISTRICT

Ed Edelman, Supervisor
974-3333

HEALTH CARE FACILITIES

Name of facility	Address
1. LAC/USC Medical Center (****)	1200 N. State St. Los Angeles
2. Montebello Satellite Clinic (**)	1221 W. Whittier Bl. Whittier
3. Central Health Center (**)	241 N. Figueroa Los Angeles
4. Hollywood/Wilshire Health Center (**)	5205 Melrose Ave. Los Angeles
5. West Hollywood Sub-Center (**)	621 N. San Vicente Bl. Los Angeles
6. Northeast Health Center	2032 Marengo St. Los Angeles
7. East Los Angeles Child & Youth Clinic	929 N. Bonnie Beach Pl. Los Angeles
8. Bell Gardens Sub-Center (*)	6912 Ajax Ave. Bell Gardens
9. van Nuys Sub-Center (**)	14340 Sylvan St. Van Nuys (West Valley)
10. Edward R. Roybal (****) Comprehensive Health Center	245 S. Fetterly Ave. Los Angeles

The following services have been eliminated at all of the facilities listed above: Outpatient Pharmacy, Medical Social Workers, Nutritionists, and Health Education.

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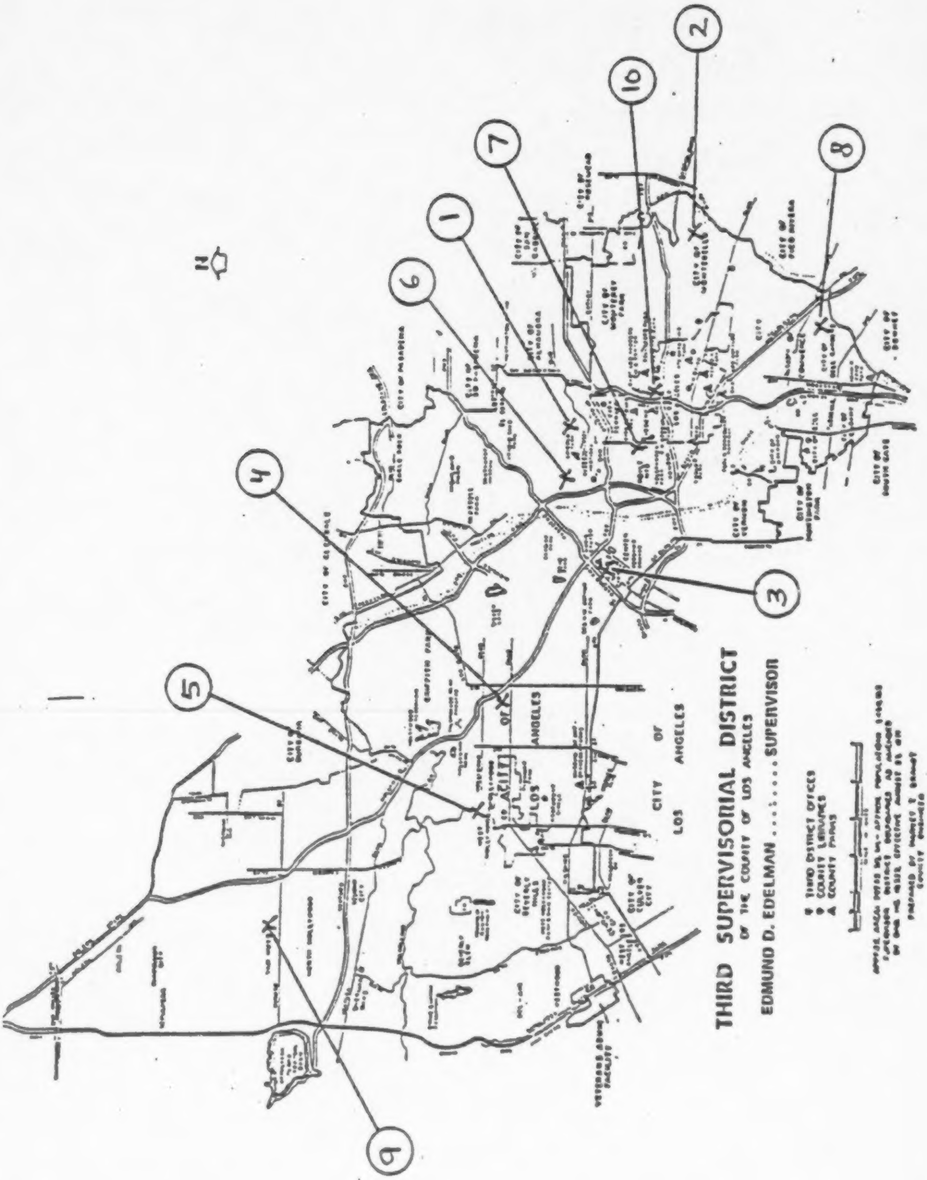
* CLOSED
** Eliminate Ambulatory Care (Walk-in service)
*** Eliminate Renal Dialysis
**** Reduce or eliminate Dental Service


THIRD SUPERVISORIAL DISTRICT
OF THE COUNTY OF LOS ANGELES
EDMUND D. EDELMAN . . . . SUPERVISOR
THIRD DISTRICT OFFICES
COUNTY LIBRARIES
COUNTY PARKS
CITY OF LOS ANGELES
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FOURTH SUPERVISORIAL DISTRICT

Deane Dana, Supervisor
974-4444

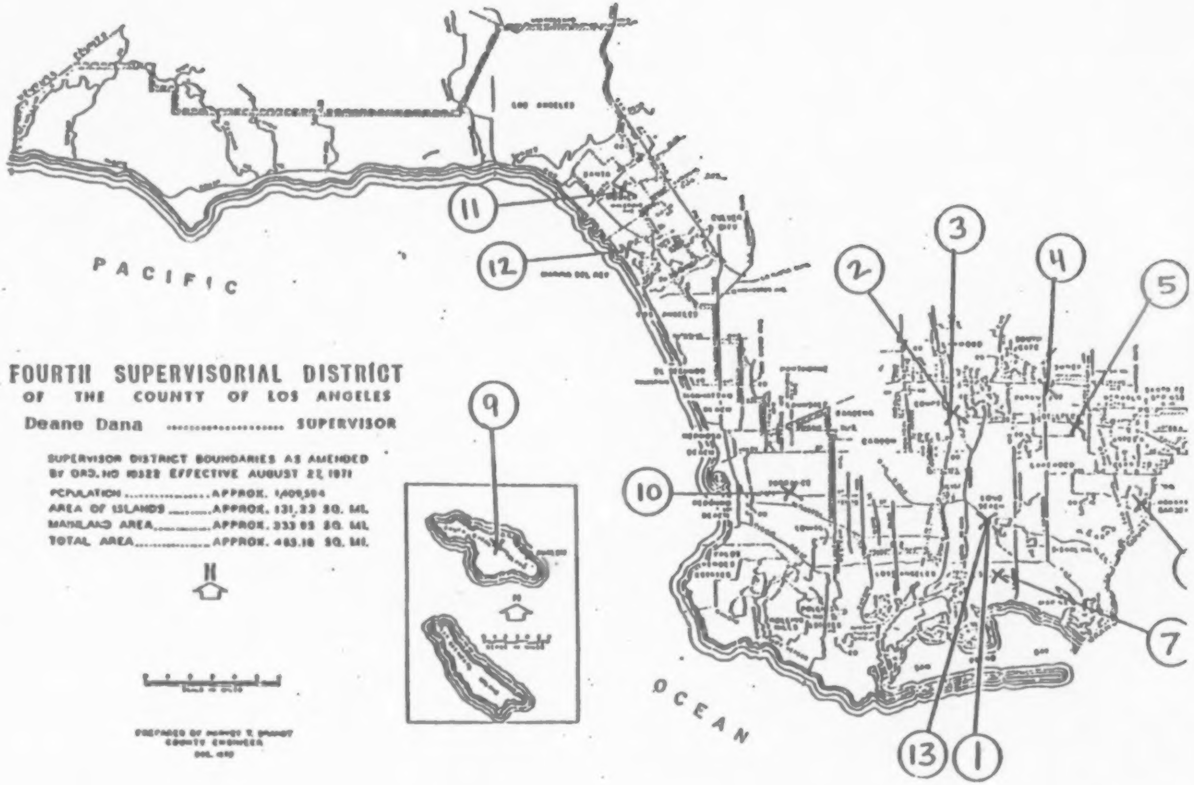
HEALTH CARE FACILITIES

	Name of facility	Address
1.	Long Beach Hospital (***) (****)	2597 Redondo Ave. Long Beach
2.	Compton Health Center	300 E. Rosecrans Ave. Compton
3.	Dollarhide Sub-Center (*)	1108 N Oleander St. Compton
4.	Paramount Sub-Center (**)	15312 Paramount Bl. Paramount
5	Bellflower Health Center (**)	1000 E. Flower Ave. Bellflower
6.	Hawiian Gardens Sub-Center (**)	22101 Norwalk Bl. Hawiian Gardens
7.	Harbor Health Center (**)	122 W. 8th St. San Pedro
8.	Wilmington Sub-Center	1325 Broad Ave. Wilmington
9.	Avalon Sub-Center (**)	215 Summer Ave. Catalina Island
10.	Torrance Health Center (**)	2300 W. Carson St. Torrance
11.	West Health Center (Yvonne Burke)	2509 Pico Bl. Santa Monica
12.	Venice Sub-Center (**)	905 N. Venice Bl. Venice
13.	El Cerrito Health Center	1401 Chestnut Long Beach

The following services have been eliminated at all of the facilities listed above: Outpatient Pharmacy, Medical Social Workers, Nutritionists, and Health Education.

The following services, marked with asterisks(*****), have been eliminated or seriously reduced.

*	CLOSED
**	Eliminate Ambulatory Care (Walk-in service)
***	Eliminate Renal Dialysis
****	Reduce or eliminate Dental Service


FOURTH SUPERVISORIAL DISTRICT
OF THE COUNTY OF LOS ANGELES
Deane Dana .... SUPERVISOR
SUPERVISOR DISTRICT BOUNDARIES AS AMENDED
BY ORD. NO 10322 EFFECTIVE AUGUST 22, 1971
POPULATION ....APPROX. 1,409,504
AREA OF ISLANDS ....APPROX. 131.33 SQ. MI.
MAINLAND AREA..............APPROX. 333.85 SQ. MI.
TOTAL AREA....................APPROX. 485.18 SQ. MI.
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PACIFIC
OCEAN
LOS ANGELES
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FIFTH SUPERVISORIAL DISTRICT

Mike Antonovich, Supervisor
974-5555

HEALTH CARE FACILITIES

	Name of facility	Address
1.	Olive View-Midvalley Hospital (***) (****)	7533 Van Nuys Bl. Van Nuys
	-Sylmar	14445 Olive View Dr. Sylmar
2.	Mira Loma Hospital (***) (****)	44900 N. 60th St. West Lancaster
3.	Glendale Health Center	501 N. Glendale Ave. Glendale
4.	Burbank Sub-Center (**)	1101 W. Magnolia Bl. Burbank
5.	E. Valley/No. Hollywood (**) Health Center	5300 Tujunga Bl No. Hollywood
	-E. Valley	Additional space 11302 Weddington
6.	Tujunga Sub-Center (**)	7747 Foothill Bl. Tujunga
7.	Pacoima Sub-Center (*)	1330 Van Nuys Bl. Pacoima
8.	San Fernando Health Center	604 S. Maclay Ave. San Fernando San Fernando Annex Bldg. 1043 Griffith
9.	Valencia Sub-Center (**)	23763 W. Valencia Bl. Valencia
10.	Canoga Park Health Center	7101 Remmet Ave. Canoga Park
11.	Antelope Valley Health Center	44855 N. Cedar Ave. Lancaster
12.	Alhambra Health Center (**)	621 West Shorb Alhambra
13.	Palmdale Sub-Center	3101 Ave. Q Palmdale

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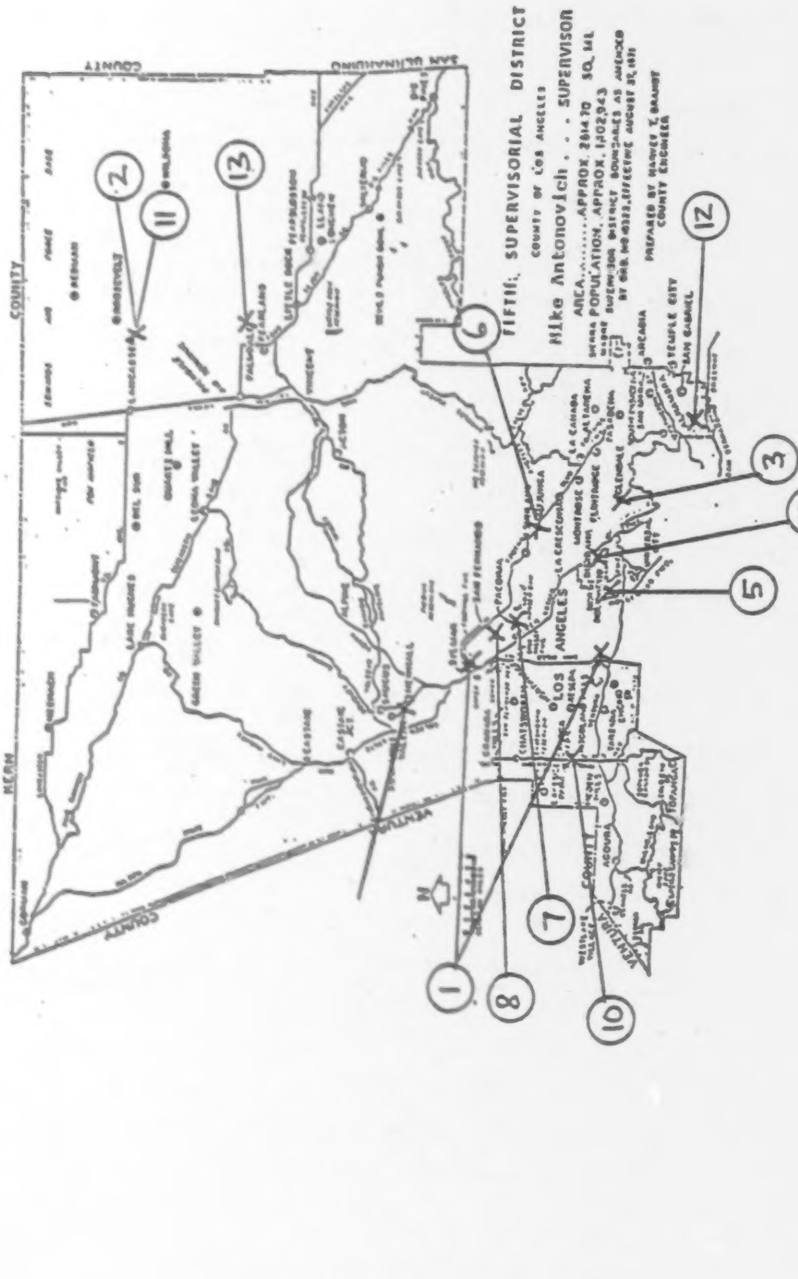
*** Eliminate Renal Dialysis
**** Reduce or eliminate Dental Service


FIFTH SUPERVISORIAL DISTRICT
COUNTY OF LOS ANGELES
Mike Antonovich . . . SUPERVISOR
AREA.........APPROX. 2814.70 SQ. MI.
POPULATION. APPROX. 1,302,943
SUPERVISORIAL DISTRICT BOUNDARIES AS AMENDED
EFFECTIVE AUGUST 27, 1971
PREPARED BY HARVEY T. BRANDT
COUNTY ENGINEER
KERN
COUNTY
SAN BERNARDINO
COUNTY
VENTURA
COUNTY
N
LOS
ANGELES
LANCASTER
PALMDALE
SAN FERNANDO
PACOIMA
LA CRESCENTA
MONTROSE
LA CANADA
ALTADENA
PASADENA
GLENDALE
ARCADIA
TEMPLE CITY
SAN GABRIEL
CHATSWORTH
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Chairman RANGEL. You can send additional information to the committee and if you could break it out by congressional district, it will allow us to bring it to the attention of the effective members. The record will remain open if there is additional testimony that you think that you would want to prepare. I want to thank you on behalf of the full committee and the subcommittee for the information that you have given to us, that we hope that we can bring about some changes when we return to our Nation's capital.

Thank you so much.

We now have the panel of members of the health brain trust of the Congressional Black Caucus.

John Noble, president emeritus of the National Association of Black Health Services Executives, unfortunately had to leave. However, his full testimony will be entered into the record.

[The material follows:]

COMMITTEE ON PUBLIC POLICY ANALYSIS

POLICY BRIEF

Number 2

Impact of Federal cut-backs
in Medicare and Medicaid
funding and the subsequent
impact on the minority
community.

January 11, 1982

National Association of Health Services Executives
840 N. Lake Shore Drive
Chicago, Illinois 60611

Presented to:

Honorable Charles B. Rangel,
Chairman of the Subcommittee
on Oversight, Committee on
Ways and Means, U.S. House
of Representatives

National Association of Health Service Executives
Committee on Public Policy Anaylsis

Policy Brief Number 2

Impact of Reduced Funding for Medicare and Medicaid Programs on the Minority Community

Executive Summary

The financial solvency of hospitals, especially those hospitals serving high proportions of medically indigent patients, led to Senate hearings on financially distressed hospitals. The American Hospital Association, later, completed an analysis on financially distressed hospitals.

The purpose of this Brief, is to recite AHA's findings as background of an existing grave situation, which undoubtedly, will be exacerbated by recent and proposed funding reductions by the Reagan Administration. Further this brief will point out the potential impact these reduction will have on the minority community.

The AHA study examines the unprecedented effects of a wide range of potential influences on the hospital financial performance. The basic findings suggested that distressed hospitals, in comparison with other hospitals, were smaller, somewhat more dependent on outpatient revenue and more likely to be public general hospitals.

AHA's study points out the following factors about distressed hospitals when comparing them to hospitals that perform well financially:

- Higher ratios of outpatient visits to inpatient admission.
- Higher levels of bad debts and charity care as a percent of net revenue.
- Smaller bed size, lower occupancy, but a somewhat greater percent increase in staffed beds Between 1977 and 1979.
- Greater likelihood of being: in U.S. census region 2 (comprised of New York, New Jersey, and Pennsylvania), region 4 (Ohio, Indiana, Illinois, Michigan, and Wisconsin), or a public general hospital regardless of region, occupancy, bed size, bed growth, bad debt and charity care levels, or outpatient relative to inpatient volume.

- Greater financial dependence on Medicare and Medicaid funding.

- Longer average collection period for Medicare payments.

- Somewhat greater likelihood of being in Standard Metropolitan Statistical Areas (thus more likely to be urban).

The National Association of Health Services Executives' examination of the AHA's study suggests the addition of the following factors which need to be considered in developing public policy with regard to distressed hospitals.:

- Based upon location of distressed hospitals, they tend to be the largest single employer of the community.

- Tend to provide the greatest opportunities for the employment of minority health administrators and minority health workers.

- Tend to provide the greatest opportunities for residency--placement of the minority graduate resident in health administration.

- Periods of high unemployment exacerbates the problem.

The factors identified in the examination suggest that sucess in reducing distress without reducing rural and inner-city populations' access to care may very well depend on:

- Provision of incentives that will force creativity and effectiveness of Hospital Management.

- Changes in health financing and payment practices.

From another perspective, the National Association of Health Services Executives would also suggest that the impact of further limitations on Medicare and Medicaid financing of hospital care would be felt more severely by presently distressed hospitals than by others. The findings, coupled with the current outlook for Medicare and Medicaid funding, underscore the need for further exploration of policy options to protect rural and inner-city populations who rely on distressed hospitals for health care and in some instances the only opportunity for employment.

The National Association of Health Services Executives would like to emphasize the impact of Medicaid funding limitations because hospitals serving large populations of the poor have a dependency on Medicaid funding which ranges from 10% to an excess of 79% of total patient revenues (see Table A). The impact of Medicaid funding limitations would fall unevenly on these hospitals:

- New York, Pennsylvania, Michigan and California, where unemployment is extremely high, account for greater than 30 percent of federal Medicaid spending. (see table B.)
- Individual hospitals represent a wide range of dependency on Medicaid income, with public general hospitals as a whole being more dependent than other hospitals.

Outlook

With a continual push by the Reagan Administration to reduce federal health funding, state governments can be expected to accelerate cost saving efforts under their Medicaid programs.

The Reagan Administration's unprecedented proposal to let states charge poor people "nominal" fees for basic physician services and hospital care will carry the following risks both for the poor as well as the institutions serving the poor:

- Poor people will tend to delay treatment in the early stage of an illness, resulting in greater hospitalization, costing the governnment more, not less.
- Hospitals, will be forced to reduce services, because of a reduction in total revenues and an increase in bad debt and charity.
- Hospitals with high dependency on federal funding, will be forced to close their door, severely disrupting accessibility to care for the poor.

Because of the divergence in trends between Medicaid costs and state and federal government resources, Medicaid cost containment is expected to be an important policy concern at the state and federal level. At least over the next several years, states will experience pressure to both intensify and expand their range of Medicaid cost containment efforts, especially if the federal government begins limiting the growth of its funds available for Medicaid matching. However, there are guarantees that some intensified combination of present governmental cost containment approaches will prove optimal in either the short- or long-run. Further innovation in Medicaid financing to indicated, to effectively contain costs while maintaining adequate access for poor to high quality health services.

Conclusion

The National Association of Health Services Executives would strongly support financial innovations that recognizes the following:

- Cost-Containment - recognizes proven alternatives to inpatient care.
- Unsponsored Patients - recognizes that urban inner-city hospitals, particularly the public generals, provides services to a large segment of the population not covered under either Medicaid or Medicare, nor do many of these people have the ability to pay.
- Creativity and Innovations - recognizes hospital management's efforts to provide services at a lower cost without impairing the quality of the services.
- Value added - recognizes that many hospitals serving the poor, are the single most employer of the poor, providing jobs and training opportunities to minorities that would not otherwise exist.
- Unemployment - recognizes that during periods of high unemployment, hospitals that already serve large portion of the medicaid population tend to be impacted more with further funding limitations.

Chairman **Rangel**. Mr. William Jackson, president, City of Memphis Hospital and Andre Lee, executive director, Hubbard Hospital, Nashville.

Let me thank all of you for the contributions you have made, not only as it relates to this committee, but the Black Caucus is a deep concern here.

Mr. Jackson, it is good to see you again. We have got a feel of the problems you are faced with.

STATEMENT OF WILLIAM JACKSON, PRESIDENT, CITY OF MEMPHIS HOSPITAL, MEMPHIS, TENN.

Mr. **Jackson**. Thank you, Mr. Chairman.

Basically there hasn't been a lot changed since I testified earlier and in the interest of time, I have submitted this report which is just a brief update from that time.

What I would like to take the time today to do and to get as part of the record, just kind of really bring you up to date on where we are in Memphis right now.

Chairman **Rangel**. Your full statement will be entered into the record without objection.

Mr. **Jackson**. Thank you.

Memphis, Tenn., is right on the threshold of experiencing most of the types of problems that we have been hearing about today as getting ready to happen or threatening to occur. We have experienced significant deficits over the last 4 years. In this particular budget year we started out with a $7 million deficit. That has been reduced to about $2.5 million level.

We have already been saddled with State medicaid reductions. There has actually already been some effect of the operations of the block grants type approach where the State cut several maternal/child health programs actually prematurely, thanks to again mostly efforts of Congressman Ford we were able to get those reinstated at least through June 30.

We have gone through a fairly significant audit process that relates to the dissolution of the former hospital authority and we are right at the point now and, in fact, I anticipate that within about 30 to 45 days, we will be going back to the county and saying that because of the funding problems in the past, because of the funding problems in the present, both related to the State level as well as the projected Federal level, we have already done all we can to achieve savings, operate more effectively. We have laid off approximately 350 employees. We have reduced services. We have scaled the size of the hospital down to a bare minimum of about 350 adult beds at this point in time. And we still are facing about a $2½ to $3 million deficit for the remainder of this budget year. And basically, they are going to be asked to either provide funding which, for your information, this is an election year at the local level and there will be probably a tremendous opposition to doing anything to actually raise the money.

Chairman **Rangel**. But if it is not funded, as the chief executive officer, when it reaches the point that you cannot provide quality health care, what do you do?

Mr. **Jackson**. We will have to if, if our request is not answered, balance the budget. And it appears now that the only way we will be able to balance that budget will be reducing services first—those that we haven't already reduced—but trying to at least maintain the same level of beds. We think that is going to be virtually impossible. We think what's going to have to happen is we are probably going to have to reduce the number of beds additional. That is going to be the only way we can actually balance that budget.

Now, the reality of that is we would then be put into the position of rationing care because as the provider of last resort—that very popular term right now—we still have the majority of those patients who are going to come to us because they don't have that access to any other facilities in town.

Chairman **Rangel**. Well, who would be there to tell them that they will be denied treatment? What kind of security forces do you have at the hospital?

Mr. **Jackson**. We have security department. It will cause some problems but that will essentially have to be policy if it gets to that point. The policy will be communicated to the emergency room physicians as well as the clinic physicians that the beds have been reduced and you just can't admit if you don't have the capability to do so. I don't know how that is all going to work out realitywise.

Chairman **Rangel**. I don't understand what you are saying. That you can tell the doctors and the nurses in the emergency room that you can't admit?

Mr. **Jackson**. Yes. Well, we can tell them that because you can't admit if you don't have any beds to put them in.

Chairman **Rangel**. Normally those patients come with their loved ones, don't they?

Mr. **Jackson**. Most of them.

Chairman **Rangel**. They are not sick.

Mr. **Jackson**. No, and they do have a tendency to perform. We have experienced that. But I don't know what's going to happen, but that looks like that's going to be the situation that I see us in in about 45 to 60 days.

Chairman **Rangel**. I was really hoping that since the picture was really as dismal the last time you testified before our committee, that other people in Memphis and the State of Tennessee would really see the impact that it was going to have on the very lives of people and that somewhere along the line there would be some stopgap measure taken so that the things that you and I are talking about that civilized people don't even have to discuss.

Mr. **Jackson**. Well, we had a very, what I thought was a cordial meeting with the commissioner from the commission of public health for the State who came down and visited with us and the board, was extremely supportive of trying to work within the current confines of medicaid regulations to do whatever could be done.

But as we explored that further on a more detailed basis for what type of short-term relief we could expect, there really was none. And it really appears right now if there is any type of relief, it will be the result as unfortunately these types of things occur, the last-minute crisis type situation when we say, "Hey, this is where we are and that's it." It always is. It takes away your ability to plan and be prepared.

That's where we are.

Chairman **Rangel**. Well, you will be participating in the conference.

Mr. **Jackson**. Yes.

Chairman **Rangel**. I know they will be anxious to hear from you.

[The prepared statement follows:]

STATEMENT OF WILLIAM JACKSON, PRESIDENT, CITY OF MEMPHIS HOSPITAL

Mr. Chairman: I am William Jackson, President of City of Memphis Hospital. I appreciate this opportunity to share with you the concerns of our hospital and the patients it serves. The City of Memphis Hospital is acutely aware of the problem of rising health care costs and our awareness is reflected in the very serious cost containment program which we have implemented over the past several months. We have instituted many cost saving measures in order to offset what was projected to be a $7 million deficit operation this year including a lay off of over 300 employees. As health professionals and taxpayers, we are also appreciative of the efforts of federal, state and local governments to better control the rate of increase in spending on Medicare and Medicaid programs.

We believe that our situation at City of Memphis Hospital is somewhat special, since we, like about three or four other large hospitals in the State of Tennessee are considered to be a "last resort" provider. This simply means that when all possible sources of financing for a particular patient are exhausted, we must assume the welfare role of providing health care anyway. As a result, our hospital, along with the other "last resort" providers, becomes the only choice for patients whose limited Medicaid benefits have been used up in other hospitals. This is why we often cry the loudest when cost cutting measures such as the reduction in annual days of eligibility for Medicaid recipients are instituted. The simple fact is that other providers, without local government funding, are unable financially to admit the patient for further care, after his days of Medicaid eligibility are used up.

As a result of increasing health costs associated with inflation and improvements in technology, many hospitals today are experiencing financial difficulties. Of course, such financial distress is not new for hospitals which serve the indigent patient. The City of Memphis Hospital, like many facilities developed to serve the poor, has suffered from years of inadequate funding from all sources. As a result, the general public often believes that medical care provided to the poor costs less than care provided to paying patients. As a continuation of the cycle, funding from several sources has thus been reduced continually for a number of years.

The City of Memphis Hospital suffered losses of $1.6 million in fiscal 1978, $6.3 million in 1979, $3.4 million in 1980, and $7.7 million in fiscal 1981. The situation has deteriorated to the point where the hospital was quite literally facing bankruptcy this year. The layoff of over 300 employees, along with a cutback in services and other stringent cost cutting measures, has reduced our deficit by about $4 million, resulting in a temporary respite from our problems. However, cuts already implemented and those proposed to the Tennessee Medicaid program will be disastrous to our already strained financial condition.

The application of two regulations, restricted Medicaid coverage and weekend admission, have serious financial implications for us. During the months of September and October, 72 claims filed as emergency weekend admissions were rejected as being non-emergent. An additional 28 claims were rejected during the same period because of restricted coverage. I would like to share with you a few examples of the rejected claims. Patients names are omitted to preserve confidentiality.

Patient A was admitted on a Saturday, hospitalized for 12 days for mitral stenosis (a cardiac condition), cerebral palsy and unspecified anemia. This claim was rejected as being non-emergent.

Patient B was hospitalized 18 days for diabetes mellitus and chronic monocytic anemia syncope episode (a condition which causes unconsciousness). Claim was rejected as being non-emergent.

Patient C was hospitalized 18 days for iron deficiency anemia and urinary tract infection. Claim of $5,824.05 was rejected because of the patient's restricted Medicaid coverage.

A study of the total financial impact of these and other recent Medicaid reimbursement changes on the City of Memphis Hospital shows we are facing a reduction this year of over $2.5 million in Medicaid payments, just at the time when we can least afford it.

Our hospital provides medical care to over 200,000 individuals each year. These patients are not solicited by us, they come of their own accord. Most do not have other options available. When the Medicaid cuts were enacted several months ago, several hospitals in Tennessee, including some in the Memphis area, were forced to limit services to Medicaid patients. As a result, our hospital is faced not only with reduced funding for our current Medicaid load, but with the additional financial burden of caring for Medicaid patients who previously were served by other hospitals. We hope that future plans for reducing the cost of the state's Medicaid program will give adequate consideration to the special problems of the City of Memphis Hospital and other "last resort" providers. However, we are aware that our state and others are facing severe cuts in funding from the federal level and are not prepared to handle these drastic cuts in such a short period of time.

It is difficult for anyone to realize the magnitude of the problem of providing indigent care at an institution the size of City of Memphis Hospital. But consider these facts. Our Emergency Room with approximately 80,000 visits annually is among the busiest in the country. Approximately 10 percent of all infants born in the State of Tennessee are delivered at City of Memphis Hospital. Our system of 52 specialty and subspecialty outpatient clinics, with over 100,000 visits each year, is one of the largest in the southeast. We have at our Hospital one of the top perinatal centers in the country. Training is provided for hundreds of medical, nursing, and allied health professionals each year at our hospital. Yet the current Medicare and Medicaid reimbursement formulas do not fully cover our costs associated with teaching and outpatient care, even though outpatient care has been identified as being much more cost effective than inpatient care. Since 9 out of 10 patients who visit our facilities come through either the Emergency Room or one of our clinics, we are forced to underwrite a large percentage of the cost of providing care to these Medicaid and other patients. And still we are asked to do more.

Mr. Chairman, unless methods are found which protect indigent care hospitals while assuring the solvency of the Medicaid program, health care for the poor, those who need it most, is in serious jeopardy. We urge you to review very carefully any proposals for further reductions in funding of the Medicaid program to ensure that appropriate exemptions are built in for special facilities such as the City of Memphis Hospital and other "last resort" providers.

STATEMENT OF ANDRE L. LEE, DPA, EXECUTIVE DIRECTOR, HUBBARD HOSPITAL, MEHARRY MEDICAL COLLEGE, NASHVILLE, TENN.

Mr. **Lee**. I am Andre Lee, executive director, Hubbard Hospital, Nashville, a teaching facility, and I would like, if it is permissible, to submit my testimony in writing at some other date and highlight here this evening.

I would also speak for Mr. Noble, who had to catch a plane. He's the commissioner of hospitals for St. Louis, and he was going to give testimony on behalf of the National Association of Health Service Executives, which is the professional arm of the Black Hospital Administrators. And since we are all members, I will give both testimonies and I think he has already submitted his written testimony and I will highlight both of them.

Speaking for myself, Hubbard Hospital is a teaching hospital and we are based in Nashville, Tenn., and we have a long history of serving the poor and indigent. At the present time our level of indigency is about 70 percent of our revenue budget which brings on grave concerns for us when you talk about cutbacks.

As I said, rather than give details here, what I would like to do is speak to the impact as I see it when the Secretary speaks of competition and I think it is a little bit unfair to ask us to compete when we are already carrying a heavy load and we are 10 paces behind the times as it is. I think it is not fair for them to talk about imposing limits on nursing differentials when we as public hospitals have inadequate staff and union contracts. I also think it is unfair to talk about limiting ancillary charges when our cost basis, as some of the previous presenters have stated, is already loaded with contractual commitments. And high overhead service areas such as obstetrics, emergency rooms, and areas which other for-profit institutions don't provide and don't care to.

I also think it is unfair to talk about competition and limitations when you are talking about imposing unreasonable copays on indigents, on recipients, without due consideration for individual circumstances, all of which will only cause us as public hospitals to ultimately either ignore the copays and absorb the loss or not render the service.

For that reason, whereas it is projected that 25 percent of the Nation's hospitals will be affected by room charges, based on some calculation of mean, Hubbard Hospital as a teaching insitution, would have to ask exactly whose mean are you talking about? Considering that our mean is already above average because as a teaching hospital we have a responsibility to conduct teaching practices for the future minority professionals of the world.

What I would like to do, since we are talking about competition, is talk about alternatives, alternatives as I see them for public hospitals, besides turning away recipients and not rendering services, are: One, since we do have a wide range of services already in place, I think that we as hospitals ought to consider submitting a comprehensive prepayment type plan to the State's medicaid agencies or an approach I call the block bed plan whereby the State contracts with us for a year for a set number of beds at a set rate. That, in turn, would guarantee us a set amount of income and we don't have to worry about overhead, billing costs, and that sort of thing.

I think they also should consider improved funding of cheaper variations of ambulatory services such as outpatient services, home care services, elderly day care centers, wellness programs, health education programs and other equally innovative ambulatory programs.

I think that ultimately they should also consider the swing bed concept which has been bantered around for some time and I think in terms of the swing bed concept which is only getting lip service at this point, they should allow us, when we have empty beds, to swing those beds into long-term care or acute care or any other alternate care with appropriate guidelines which will save us money. I think it is ludicrous to talk about closing hospital beds when it costs $100,000—plus to build a new bed and then they turn right around and give a new bed to another institution because they claim the population is shifting, leaving us with just the poor and the indigent to take care of.

These are pretty much the highlights of my own statement and presentation which I think that the Government should consider.

And I also think that one other point is that when they talk about cuts, rather than rendering the cuts on a broad sweeping basis, that they ought to make special dispensation for the public hospitals who carry an unreasonable load of providing care to the medicaid, the poor, the indigent and the handicapped, because I think with that type of consideration, perhaps then we might reasonably consider service to these people.

Speaking on behalf of the National Association of Health Service Executives, what NASHE did was take a look at the American Hospital Association study of distressed hospitals and in that particular study, the American Hospital Association pointed out that distressed hospitals had certain characteristics. One of them was that they had a high ratio of outpatient visits to inpatient admissions; two, higher levels of bad debt and charity care as a percent of the net revenue; three, smaller bed size, lower occupancy but a similar greater percent increase in staff beds between 1979 and 1977; they also had, four, greater likelihood of being in high census areas, concentrated urban areas, such as the States of New York, New Jersey, Pennsylvania, Ohio, Michigan, Indiana, et cetera; five, greater financial dependence on medicare and medicaid funding; six, longer average collection periods for medicare payments; and, seven, somewhat greater likelihood to be in standing metropolitan statistical areas.

Now, NASHE would like to add to that, based on that study, that the location of the distressed hospitals, that these hospitals tend to be the largest single employer in the community. Second, they tend to provide the greatest opportunity for the employment of minority health administrators and minority health workers; and, three, tend to provide the greatest opportunity for residency places for minority residents in health administration; and, four, they have periods of high unemployment in those areas only serving to exacerbate the problems that they face.

The outlook as NASHE sees it is as follows: With the Reagan push to reduce Federal funding and the proposal to let the States charge poor people nominal fees for physicians' services and hospital care, the risks to institutions serving the poor are as follows: Poor people tend to delay treatment in the early stages of an illness, resulting in greater hospitalization, costing the Government more—not less; two, hospitals will be forced to reduce services because of a reduction in revenue and increases in bad debt and charity; and, three, hospitals with high dependency on Federal funding will be forced to close their doors, severely disrupting accessibility to care for the poor.

In conclusion, therefore, NASHE would strongly support the following financial innovations to accomplish the following: Cost containment recognizes prudent alternatives to inpatient care; unsponsored, recognizing that urban inner city hospitals, particularly general hospitals, provide services to a large segment of the population not covered under even Medicaid or Medicare, nor do many of these people have the ability to pay; creativity and innovation recognize hospital managers' efforts to provide services at a lower cost without impairing the quality of service; recognizing that many hospitals serving the poor are the single most largest employer of the poor, providing jobs and training opportunities in minorities that would not otherwise exist; and unemployment, recognizing that during periods of high unemployment, hospitals that already serve large portions of the medicaid population tend to be impacted more with further funding limitations.

Thank you.

Chairman RANGEL. Thank you, Doctor. What is the National Association of Black Executives?

Mr. **Lee**. Health service executives.

Chairman **Rangel**. How long has this organization been in existence?

Mr. **Lee**. Since 1968.

Chairman **Rangel**. Have you ever testified before the Ways and Means Committee or its Health Subcommittee?

Mr. **Lee**. I don't know if various other members might have. Our presidency is changing every 2 years now and right now it is Bernard Dickens, who is based in Chicago, and the past president was Mr. Noble, who was not able to remain here. Our incoming president is Mr. James Hazel, who is based in Columbus, Ohio.

Chairman **Rangel**. Is he at this conference?

Mr. **Lee**. I don't think he's here. He works for Wright State University in their health clinic. Our members work in various other capacities besides public hospitals. So he is not here, I don't think, at this particular meeting.

Chairman **Rangel**. Well, I think that your expertise in this area will be invaluable to this committee. What I have heard from the other people is it looks like the ax is going to fall on the poor and the minorities, and when you talk about health care employment you could be of great help to the Nation and this committee if we could consolidate that type of information as it relates to these types of communities.

I don't think that it is any surprise why we have so many black executives where the hospitals are located or why we're not getting the type of financial support and I know who will be closing the doors. But it would be helpful if we could bring that information together so that it would assist this committee a great deal.

Let me thank both of you for your patience in what has been a very long hearing. I wish you success at your conference here and as I said to the other panel members, that our staff members are prepared to assist you in some of the problems that you face in your day-to-day problems in getting through some of the redtape of bureaucracy.

We wish you well and look forward to continuing working with you.

Mr. **Lee**. Thank you.

[The following was subsequently received:]

STATEMENT OF ANDRE' L. LEE, DPA, EXECUTIVE DIRECTOR, HUBBARD HOSPITAL, MEHARRY MEDICAL COLLEGE, NASHVILLE, TENN.

Mr. Chairman, distinguished members of the Committee, I appreciate the opportunity to present not only my institution's position regarding the budgetary cut backs but those of like brethren public and Black hospitals. I don't believe in making complicated statements where the simple truth will do. Particularly since medical finance is a complex business and one which I suspect we truly have no experts only manipulators.

One thing however is crystal clear, no matter how the government cuts, imposes limits, or tightens guidelines the end result will be the same as it always has been, the consumer will either pay or see less service. The concern that I have today, however, centers like my colleagues on the financial impact on public hospital operations.

Hubbard-Meharry Hospital is a medical teaching institution of 405 bed capacity. We have a long history of service to the poor and indigent. In recent years we have seen that indigent level grow at a steady increase to a point where 75% of our revenue is cost based. Simultaneous with these increases we have also witnessed service after service, negative rule changes, caps, etc. Historically all of these moves were made piece meal and with a broad sweeping stroke with little regard for hospital groupings. While my colleagues have elucidated rather succinctly the impact on individual hospital operation, it should be abundantly clear that the actual impact will not be felt equally within the hospital brotherhood.

I'd like to take two basic approaches in my testimony. The first will simply state our case as public hospitals. We will suffer, as we always have and we shall let the record be clear in that regard. The second approach is my own basic bias against being critical without offering some viable alternatives for consideration.

Public hospitals have long been the silent suffering segment of the hospital community. We get all of the unwanted, the difficult to care for. We were their haven of refuge before the government enforced Hill Burton charitable parity. We have a moral heritage in this regard and it is not necessarily a duty we shirk. At the same time we have steadfastly, quietly stood by and watched cut after cut, sanction after sanction without distinguishable regard to the impact on different types of hospitals. While we do not expect the government to achieve the same level of reimbursement as Blue Cross, Aetna or other major Third Party payors, it is, nonetheless, common knowledge that current Government reimbursement for room rates, ancillary services, etc are woefully inadequate. Cost based reimbursement review seemingly always manages to end up reimbursing for less than cost due to government regulations, disallowable costs, and off setting rules pitting incoming cash against other legitimate expenses. In public hospital circles parlance, it means that depreciation accounts don't get adequately funded, equipment is not the state of the art, technical skills become antiquated, trained reputable professionals refuse to join and ultimately we find ourselves unable to keep pace and compete.

So when the government talks about competition, it cannot assume that we are all starting from the same starting point. Many of us are beginning 10 paces back and shouldering a 100-lb. load. It is unfair to talk about lowering the per diem rate without looking at the patient 3rd party mix.

It is unfair to talk about imposing limitations on nursing differentials when we as public hospitals are loaded with inadequate staff and union contracts.

It is unfair to talk about limiting ancillary charges when our cost base is a based loaded with union contractual commitment and high service area overheads such as obstetrics, emergency room, etc., areas which for-profit facilities overlook.

It is unfair to talk about imposing unreasonable cash co-pay on recipients without due consideration for individual circumstances. All that will do is cause us to ignore the co-pay and absorb the loss. Other hospitals less saddled with political service realities will simply send the recipients to us.

This is an imperfect medical world and for that reason the imposition of cut backs must be done with regognition that the impacts will not be shared equally. HCFA projects that 25% of the nations hospitals will be affected by the routine room charge limitations based on a calculation of % of mean. Hubbard is a teaching hospital, therefore automatically our mean is going to be substantially higher than other area hospitals. Whose mean do we use? At 108% of the mean, the 8% is meager tokenism in an inflationary economy.

Before proceeding to the real substance of my comments, alternatives to the present Medicaid/Medicare system, let me quickly comment on other government proposed changes and their real consequences.

To begin with HHS seemingly proposes changes from a basis of what they want to occur without serious examination of what is most likely to occur and in all probability will occur; For instance

Secretary Schweiker seems high on a voucher system which he exhorts foster consumer choice and increased competition. This pre supposes that the consumer is knowledgeable enough to make an intelligent choice and not be taken advantage of. Historically, we have spent very few dollars on consumer health education. Chances are, people will select out of ignorance which will in turn yield room for greater fraud and misuse of funds and people.

The imposition of tax results and limitations will infuriate employees. Many of whom are already dismayed at the high cost of health care. In effect they will view it as a transfer of government responsibility to their shoulders which they will undoubtably not assume.

The last proposition I've already addressed earlier, the increase of recipient co-pay. It will serve only as an incentive to not seek Medicaid help when they need it. It'll save money but it'll also downgrade the health of our citizenship.

As I stated earlier, what is more important is the need to devise alternatives. We keep hearing new buzz words in the industry and a key one is "competition." While it is no deep dark secret that the government is keen on fostering the competitive spirit, let's be fair in the ground rules for competition.

*Don't hamper or penalize the public hospitals. We are bureaucracy laden and cash short. If we are unable to compete, you, the government, lose a valuable ally and indeed limit your choices on where government dollars will be spent or services rendered.

*Any competition requires that the prize be worth competing for. If recipients are saddled with usage limitations and the services to be rendered are limited with caps, then competition will be limited and short lived.

*Public Hospitals by and large are already equipped with a wide range of basic patient treatment services. I would propose that the government be amenable to accepting alternate financial proposals. These proposals would either provide a cost savings or widen range of services. Similar to an HMO pre-payment plan, its basic merit rests on control. Control of the patient and the dollar.

*Since I believe that many hospitals while accepting of Medicaid/Medicare patients, do not wish to see a significant rise in their patient mix complement, I would propose that public hospitals offer a block of beds to the Medicaid program. These beds, under this very simple concept would be purchased under what I call "The block bed" allocation plan. These beds would be reserved for Medicaid/ or Medicare patients under any service mix, save obstetrical or special units such as ICU/CCU. They would be prepaid for a year. The government then knows exactly what it has spent and the hospital does not bear expensive billing costs. This is a slight modification of the MIP and PIP program and in fact a logical extension of each. In short, why not designate specific centers, for recipients?

*To do business with prospective reimbursement is not the panacea for hospital finance. But we have certainly seen what retrospective can do. I would suggest that the truth lies somewhere in between. This is a very complicated undertaking and fraught with political underpinnings. Nonetheless, as the States of Indiana and Michigan have shown, it has some creditability.

*Beds - This seems to be the crux of arguments for and against cuts. Rather than talk about eliminating an acute care bed as a means of saving the dollar, why not place greater emphasis on the "Swing bed concept!". Swing bed in the sense of its ability to be alternately used as acute, long term, or some other appropriate service. Appropriate guidelines would be necessary but clearly when it cost $100,000 to build a new bed this makes a lot of sense.

*Ambulatory Services - We all know these services are cheaper and in many instances quite appropriate for the care required. The government needs to take a more serious look at funding levels for

Outpatient Service Modalities
Home Health Care Services
Elderly Day Care Centers
Wellness Programs
Consumer Health Education programs
and other euqally innovative approaches.

My final proposition speaks to the need for awareness by the Federal Government that all hospitals are not alike. Whereas they are not necessarily that dissimilar, there are key elements of a hospital which separates them from one another and yet groups them categorically. The Administrations approach is predictable in that its basic premise is as traditional as Mama's apple pie. Again the cuts are standardize while the impact is not. The government must decide what end result it is attempting to achieve service wise within a given amount of dollars. Is the aim to make all hospitals share equally service responsibility or is it to make all hospitals similar in operation and complexion or is it to make a group of hospitals conform to financial ethics? Once that decision is made, then the decisions necessary to effect a logical pragmatic dollar flow become relatively easy.

I am pleased to be allowed to express universal hospital concerns. The opportunity is rare and I certainly hope my thoughts are useful for the committee's deliberation.

I offer my services and those of my institution if need be to bring about a more equitable and reasonable approach to bring together sound medical services delivery system.

Chairman **Rangel**. Let me thank the stenographer for her patience in going through the full hearing.

The subcommittee will stand adjourned, subject to the call of the Chair.

[Whereupon at 5:30 p.m., the subcommittee was adjourned.]

[The following was submitted for the record:]

STATEMENT OF MADELINE BOHMAN, EXECUTIVE DIRECTOR, BELLEVUE HOSPITAL CENTER, NEW YORK CITY

I am Madeline Bohman, Executive Director of the Bellevue Hospital Center. Although I could not be present at the field hearings conducted by the Oversight Subcommittee in Denver, I am pleased to make these comments available to Congressman Rangel for inclusion in the hearing record. In addition, I would like to thank the members of the Subcommittee for devoting considerable time to studying the effects federal budget reductions are now having on the public hospitals in this country.

Bellevue Hospital is one of 16 facilities operated by the New York City Health and Hospital Corporation. The Corporation itself is the largest municipal hospital system in the world and is comprised of 12 acute care hospitals, 4 long-term care facilities, 4 Neighborhood Family Care Centers and numerous satellite clinics. In addition, the Corporation operates the citywide Emergency Medical Services, which responds to more than 600,000 calls each year.

Bellevue Hospital Center is a 1,200 bed teaching hospital affiliated with the New York University School of Medicine. Bellevue offers a broad spectrum of health care services and, in addition, has specialized in providing highly sophisticated tertiary services. Among the many services offered, Bellevue serves the borough of Manhattan as the designated receiving hospital, acts as a multistate tertiary resource with special expertise in treating spinal cord injuries, head traumas, and microsurgery and reimplantations; serves as a major intensive care center for adult, pediatric and neonatal patients; maintains the largest non-state psychiatric facility in New York; is a designated cardiac care station; and serves as New York City's designated hospital for care of the President of the United States and other visiting public officials and dignitaries.

Notwithstanding Bellevue's capability to provide very specialized services, the hospital also offers primary care services for thousands of individuals who have no other source for such care. Last year, Bellevue provided 360,000 days of inpatient care and experienced 497,694 outpatient department and emergency room visits. This is in keeping with the Health and Hospital Corporation's mission to guarantee quality care for every person coming to its door, no matter how poor. In fact, our patients are among the neediest. Most depend on some form of public health insurance -- particularly Medicaid and Medicare -- to cover the costs of their care. However, the Corporation treats many people who have little or no health insurance vs the so-called medically indigent -- because these people have nowhere else to go for care. The Corporation's facilities are, in the truest sense, "providers of last resort" for thousands of individuals and families. Reductions in Medicaid and Medicare place public hospitals in great jeopardy, because of the large numbers of patients treated who are beneficiaries of this program. There is no alternative source of funding available to make up for shortfalls in federal funds. In 1981 the City of New York spent over a billion dollars -- or 12 percent of its total budget -- on health services. In addition to $800 million for its local share of the state's Medicaid expense, the City provides the Health and Hospital's Corporation with a direct subsidy of $340 million. The City's resources are stretched to the fullest and we can expect no additional funds to be forthcoming.

First and foremost among the federal reductions is that provision in the 1981 Reconciliation Act of 1981 which reduces the federal share of Medicaid payments to states by 3 percent, 4 percent and 4.5 percent in federal fiscal years 1982 and 1984, respectively. While the full effects have yet to be felt, the Governor of New York has announced his intention to pass the federal cuts directly to hospitals -- both public and private -- through proportionate reductions in Medicaid rates. Given the fact that current rates fail to meet the actual costs of providing care, a rate reduction commensurate with federal funding losses will have enormous consequences. Moreover, this policy blatantly ignores the clause carefully placed in the Reconciliation Act which instructs the States, in handling funding reductions, to give special consideration to those hospitals which serve a disproportionate number of low-income patients.

In addition, the Governor intends to exercise his option to reduce a hospital's inpatient rate from an acute care rate to a lower skilled nursing facility rate for those days when a patient no longer requires acute level care. If applied strictly, this provision will mean a loss of approximately $28 million to the

Corporation as a whole and a potential loss to Bellevue of $5 to $7 million in revenues. Again, this policy violates the provision in the Reconciliation Act granting special consideration to hospitals serving the poor. Thus, application of this provision in a place like New York City where there is a chronic shortage of nursing home beds, particularly for the poor, will force a choice between two undesirable options -- keeping a patient in a hospital whose medical condition requires some level of care and losing revenues as a consequence of discharging that patient in order to avoid the financial penalty. In the final analysis, such policies reflect inhumane treatment of the truly sick patients and encourages poor medical practice.

In addition to direct funding losses, federal policies now and in the future are likely to create greater disparaties between voluntary and public hospitals. The ultimate loser in the funding battles being carried on in Washington will be the patient. Restrictions in Medicaid eligibility will create a new population of medically indigent who, lacking any kind of insurance, will be treated in public hospitals free of charge. Corollary reductions in alternative health programs such as Community Health Centers, Community Mental Health Centers, maternal and child health care programs, alcohol and drug abuse services, etc. will mean a greater strain on public hospital facilities, particularly ambulatory care clinics. Without the funds to expand our own services, patients will face overcrowded and overextended hospital clinics.

The most troubling development of all may well be a return to a two-tier health care system in this country -- one for the poor and another for the affluent. The reduction of Medicaid and Medicare coverage, the imposition of copayments as a condition for Medicaid and Medicare reimbursement and the increase in penalties and rate reduction will provide voluntary hospitals with little if any incentive to treat the poor and the elderly. Voluntaries will be reserved for those who can afford comprehensive insurance and all necessary out-of-pocket expenses. Those who cannot contribute to their own care will be referred to public hospitals on a wholesale basis.

Yet the reality is that the public sector will probably not be able to absorb the increased demand for services. At present, occupancy rates in many HHC facilities are at their highest level. Bellevue, for example, has seen the average occupancy rate jump to 86 percent (excluding newborns) since the beginning of the Corporation's fiscal year as compared to 80 percent (excluding newborns) last year. This trend is true for most of the other major hospitals in the system.

Given the obvious fixed number of beds in the system, and the present occupancy levels, it is unclear as to how our hospitals could adequately care for increasing numbers of patients, which voluntaries are likely to choose not to serve. This, coupled with the lack of resources necessary to care for these patients, paints a very troublesome picture for the availability of quality health services in New York City.

Finally, these threats to the integrity of the health care system also demonstrates the fundamental error in the current approach to health care cost containment, the stated goal of the budget reductions. Merely reducing federal outlays for health care through the changes in Medicare and Medicaid simply does not guarantee success in limiting continued increases in the expenses involved in providing quality health care. Inflation, promotion by industry of steady improvement in medical technology and, in the case of public hospitals serving the poor, the aging of an already illness-prone population will continue to drive costs up, regardless of reductions in the federal Medicaid and Medicare budget. It is the states or local governments or the providers and patients themselves who must bear these increasing costs along with the burdens created by federal reductions.

May I thank the Committee for this opportunity to discuss the impact of federal budget cuts on the public hospital system in New York City. I would be happy to provide any additional information which the Committee might need in its future efforts on these issues.

STATEMENT OF STANLEY J. BRASHER, EXECUTIVE DIRECTOR, PLAN DE SALUD DEL VALLE, INC. (VALLEY HEALTH PLAN), FORT LUPTON, COLO., ON BEHALF OF THE COLORADO ASSOCIATION OF COMMUNITY HEALTH CENTERS

Gentlemen and Lady of the Subcommittee:

My name is Stanley J. Brasher. I am Project Director of Plan de Salud del Valle (Valley Health Plan), a jointly funded Community Health Center (CHC) and Migrant Health Center (MHC), whose central office is located in Fort Lupton, Colorado.

Recently, the 12 community and migrant health federal grantees in Colorado, i.e., programs funded under Sections 329 and 330 of the Public Health Service Act, met and organized the Colorado Association of Community Health Centers. This was done largley in response to the rather dramatic shift in the role of the federal government in health care delivery and health protection that is taking place at present. The purposes of our Association are to provide a vehicle to gather and dissemenate information of significance to Colorado health centers, to conduct research endeavors, and, by pooling resources and talent, to evaluate alternatives relating to health policy and programmatic matters and to assist in the decision concerning whether Colorado accepts the newly created primary care block grant.

There are two things this short statement issued on behalf of the Colorado Association seeks to address: First, our assessment of current budget cuts for health care, and, secondly, our concerns about the administration's 1982 legislative program as it relates to primary care health centers.

First, let it be stated that CHC's and MHC's exist because there was and is a demonstrated need in the areas that they operate. They serve defined geographic areas and provide health care services for medically underserved populations as determined by a number of factors including physician shortage, infant mortality, elderly population and poverty levels. The majority of users of these programs can be characterized as having low incomes, high unemployment rates, and they often have unique and sometimes severe health care needs not being adequately or appropriately met by the existing health care delivery system. Therefore, by the very nature of the programs, they focus on the needs of the poor, the elderly and the unemployed. Budget cuts for these programs cannot all be made up, if indeed any of it can, by increased fees-for-service or patient fees in the absence of a third party pay mechanism.

While it is extremely difficult to fully assess at this time the eventual impact of budget reductions on community health centers for fiscal 1982 because no final appropriations act has been passed and signed by the President, it is clear from funding levels contained in the continuation resolution which is due to expire in March 1982, and from DHHS Regional Office directives that the impact of funding cuts will be profound in Colorado this year and perhaps for years to come if administration recommendations are followed.

In 1980, Colorado's 12 community and Migrant Health Centers provided care for more than 248,000 persons, representing 858,000 patient visits. Based on the conservative assumption that budget cuts will be no more than 25% this year (FY 1982) and if we use a straight line reduction method this means that the health needs of 62,000 less people will be taken care of by Colorado CHC's in 1982 than in 1980 with 215,000 less patient visits. Moneywise, the reduction means Colorado will receive from $2.5 million to $3.0 million less in federal funds this year compared to two years ago.

Of course, each CHC program will handle reductions differently and therefore the impact of budget cuts will be different. Small programs will tend to be devastated by a 25 - 30% cut. For example, where does a $100,000 program having a single provider (say, a family nurse practitioner) and seeing 3,000 persons per year cut back and still comply with legal requirements? In the absence of alternative funding sources, this program will have to either operate part-time or shut down completely. Either case, the patient is the loser.

The larger programs, which perhaps have a little more flexibility than smaller ones, will be and are faced with the elimination of large blocks of certain types of services or the closure of service sites. In my own center, a 25% reduction in federal funding means a $400,000 cut. While we have several options to absorb this cut, the implementation of any or all of them simply means that fewer needs can be taken care of.

Deciding on these options will be an extremely difficult and traumatic experience for our community governing board (since our program budget year begins on July 1st, the board has not yet finally decided the issue). One alternative is to close some of our satellite service sites, which were initially established to make health care more ascessible to remote populations in our rather large geographic catchment area. Another option involves the total elimination or at best the reduction of certain supplemental and allied health services such as patient transportation, nutrition counseling, health and patient education and prevention programs and podiatry and vision services. Of course, the reduction of personnel, including health care providers, is yet another option to save money. My own opinion is that our program will implement a combination of the above alternatives. But in any case, it reduces our capability to provide health services; it reduces accessibility; and it threatens comprehensiveness and continuity of care.

Another significant effect that federal CHC budget cuts or closure of CHC's in Colorado can and will likely have is to place a greater burden on private as well as public general hospitals. It is a proven experience that, without readily available and accessible primary services, the poor, who have no other alternative, will postpone needed care until such time as the condition becomes extremely acute. When this occurs, they show up at the local hospital's emergency room or go to the nearest publically supported general hospital. Not only is this very expensive care but it can place a devastating burden on these facilities. Our experience is that our public general hospitals, primarily Colorado General and Denver General, are already over-burdened and face a doubtful financial future themselves.

In short, it is our opinion that CHC and MHC budget cuts will have a great negative impact on the nation's and Colorado's primary care health centers as well as secondary and tertiary care centers, and therefore on the consumers of the services of these agencies. Further future budget reductions will simply compound this adverse impact.

Another current concern that we have is what the national administration and the Congress are considering for their legislative program in 1982, including the fiscal 1983 funding levels. Early reports suggest that the administration is planning to recommend the following:

- Expanding the Primary Care Block Grant to include the Migrant Health, Family Planning, and Black Lung Clinics, together with the Community Health Center program;

- Eliminating most of the protective provisions from the Primary Care Block Grant, including the required state match, "grandparent" clause and limitation on use of funds for CHCs only; and

- Holding FY-83 funding to the current (FY-82) levels for all these programs (which means an effective decrease in funding, when inflation is taken into account).

We wish to go on record as opposing the expansion of the Primary Care Block and of removing the protective provisions in legislation for CHCs. We also favor an appropriations level for CHCs and MHCs at least equaling last year's level (FY 1981).

Thank you very much for your time and attention.

STATEMENT OF RICHARD L. DURBIN, CHIEF ADMINISTRATOR, HARRIS COUNTY HOSPITAL DISTRICT, HOUSTON, TEX.

The Harris County Hospital District is a tax supported system made up of two hospitals, eight neighborhood health centers, and a central dental clinic. A third hospital has been purchased but is not yet renovated to allow operation. The Hospital District currently has set up and in use 740 adult and pediatric beds and 265 bassinets. Occupancy has now exceeded the 90% level. Outpatient visits total one-half million per year, with 130,000 of those visits being to the Emergency Center and 170,000 to the neighborhood health centers. In addition, the District provides home health care services through a contract with the Visiting Nurse Association.

The budget for the total District is $129,400,000 of which $11 million is set aside for capital equipment and renovations. Another $14.7 million is spent for medical staff, coming exclusively from Baylor College of Medicine. The Hospital District is the primary clinical teaching location for Baylor, which provides 276 residents and 103 full-time staff physicians. Because of the high utilization rate at the hospitals, no private admissions are accepted. This means that $100 million must come from local taxes with the remainder being made up of payments by patients and third party reimbursements to the District.

The Hospital District is the "safety net" for health care in our region. As the economy has become more and more stagnant in other parts of the country, more and more people have moved into the area seeking employment. Many are forced to turn to the Hospital District for health care. Those without work have little choice. Those who have found jobs often cannot go to private hospitals because of lack of insurance coverage or inability to pay the deposits prior to service being demanded in the private sector. These "people in the middle" are capable of meeting the normal expenses of life, but unable to cope with unexpected medical expenses. They turn to the Hospital District.

Other patients come to District facilities who are not eligible for services by State law because of not living in the County, but who must be seen because of an emergency condition which may exist. The area surrounding Harris County is largely undeveloped in terms of medical facilities. The rural population comes to District facilities when in labor or otherwise needing immediate attention. The poor from these counties also seek care bacause no public care is available in their area. Many others who live in the County but are not eligible also seek care. This group includes refugees from foreign countries who have no way of paying for private care and are not covered by Medicaid. It also includes a number of foreign students whose stipends from their homes are too small for medical costs and an ever increasing number of undocumented aliens. All these groups turn to the Hospital District.

Another group which places demands on our system are those whose third party coverage runs out, particularly Medicaid or Medicare coverage. This results in private and non-profit taking fewer and fewer Medicaid or Medicare patients as a percentage of total admissions, and then "dumping" these patients to the Hospital District when coverages get low or run out.

These mounting economic pressures are met by an increasing unwillingness on the part of local taxpayers to foot the bill for those perceived as being "someone else's problem." The "Proposition 13" attitude is spreading, with a move currently underway to reduce the Hospital District's maximum taxing level to one-third its current limit. Because of lack of funding, the District cannot compete on salaries with private and non-profit systems. Our only choice to insure quality care to our patients soon will be drastic increases in rates charged to third party payors.

Your committee can help alleviate this situation in three specific ways

First; direct assistance to the District for emergency and intensive care services rendered to patients outside our service area should be considered. Our Emergency Center is one of only two Class I Emergency Centers in the thirteen county area surrounding Harris County. As such, we get a large number of patients from outside our County and, in fact, from outside the State. Many of these patients require lengthy hospitalization, often in our intensive care areas. Our maternity center delivered in excess of 14,600 babies during the last calendar year, the largest number of deliveries in one hospital in the country. Many of these patients were from outside our service area but came to our facility because of inability to pay or be accepted by a private hospital or because their condition was "High Risk" and facilities in their areas could not provide the care required. Some form of assistance to offset these costs seems reasonable.

Second, through our involvement in the education of medical professionals, the District provides long range benefits for people in all parts of the country. Our programs include medical students and residents, nurses, pharmacists, occupational, physical, and respiratory therapists, and radiology technicians. These students, once trained, are available throughout the nation to take part in the delivery of health care. Unfortunately, the training of these individuals costs the Hospital District not only in terms of additional direct costs, but also in indirect costs such as maintaining classrooms, etc. Again, it is reasonable to ask that this burden be shared by the large population which receives the ultimate benefit.

The third area in which help is needed is that of moderization of facilities. One of the District's two hospitals was built in 1936. It was renovated in 1968 but does not meet the current needs and is far from acceptable according to Fire and Life Safety Codes. The other hospital was built in 1963 and is also in need of moderization. The last facility purchased was originally designed as a nursing home. Although it is basically in good condition, renovations are necessary to convert it for use as a hospital. Current estimates are that costs for moderization to meet patient needs and Fire and Safety requirements total $100 million. This far exceeds the ability of local taxpayers, and delays simply increase the amount as building costs increase. Direct assistance in this area is badly needed in order to insure that proper care can be rendered both to our patients and to those outside our service area.

Again, the Harris County Hospital District is the "safety net" for the people in our region. As economic factors combine to stretch that net further and further, more and more people are simply going to slip through. Your help in the areas outlined above can help prevent that tragedy.

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS 1575 Eye Street, N.W., Suite 600, Washington, D.C. 20005 (202) 789-8834

RECEIVED

JAN 29 1982

Ways and Means
Subcommittee on Oversight

JAN 27 1982

January 26, 1982

Honorable Charles B. Rangel
Chairman, Oversight Subcommittee
Ways and Means Committee
1101 Longworth House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed are written statements of Paul J. Drozd, Executive Director of the Los Angeles County/USC Medical Center; Richard L. Durbin, Chief Administrator of the Harris County Hospital District; and Ray G. Newman, Operating Officer of Parkland Memorial Hospital, prepared in connection with your hearing in Denver, Colorado, on January 12, 1982. On behalf of the members of the National Association of Public Hospitals, I would like to request inclusion of these statements in the printed hearing record. In addition, I ask that you also include in your hearing record the enclosed comments submitted by NAPH to the Administrator of the Health Care Financing Administration, which contain a summary of the current situation of urban public hospitals in America, and copies of certain articles (also enclosed) further describing several aspects of those problems.

Finally, I would like to request that you hold the hearing record open at least until February 5, to receive additional statements for the record from Madeline Bohman, Administrator of Bellevue Hospital in New York City, and possibly other NAPH members.

Sincerely,

Larry S. Gage

Larry S. Gage
General Counsel

Boston City Hospital
Denver General Hospital
Harris County Hospital District (Houston)
College Hospital of the College of Medicine & Dentistry (Newark)
District of Columbia General Hospital
Cleveland Metropolitan General Hospital
Grady Memorial Hospital (Atlanta)
Santa Clara Valley Medical Center (San Jose)
Los Angeles County U.S.C. Medical Center
Parkland Memorial Hospital (Dallas)
Truman Medical Center (Kansas City)
University of Maryland Hospital
San Francisco General Hospital
Contra Costa County Health Services Dept.
Brackenridge Hospital (Austin)
Wishard Memorial Hospital (Indianapolis)
New York City Health and Hospitals Corporation
Glades General Hospital (Belle Glade, Florida)
Chope Community Hospital (San Mateo)
Worcester City Hospital
Cook County Hospital
Alameda County Health Care Services Agency (Oakland)
Westchester County Medical Center
Milwaukee County Medical Complex

American Medical News

Residency programs may be cut

David Rosenbloom, PhD
. . . supports trimming residencies

A number of public hospital administrators predict that residency programs will be streamlined as government funding for Medicaid and Medicare is tightened.

Cutbacks in the number of residents and much closer supervision by the faculty will be among the changes, two public hospital administrators said.

These changes could have a big effect, since public hospitals train so many residents. According to David Rosenbloom, PhD, Boston's commissioner of health and hospitals, 20% of the nation's residents are trained in 90 big city public hospitals. Another 18.5% are trained in large state university hospitals and some smaller public hospitals, he said.

ADMINISTRATORS seemed to agree that there is fat in residency programs that can be trimmed. "You couldn't do residency programs more expensively than they're being done now," Dr. Rosenbloom said.

"If you said service (to patients) is our only goal, you could come up with a model that used fewer residents and was cheaper," he explained. "I think anybody can design this model.

"It's more than just the residents' salaries (that cost the hospital money)," Dr. Rosenbloom continued. "There are lab costs, support systems, supervision costs, and inefficiencies that come from frequent rotations."

HIS HOSPITAL employs 220 residents. "We have fewer this year than last," he said. "And next year, we'll have fewer than this year."

William Gonzales, director of the U. of California/Irvine Medical Center, predicted that California will force the identification of teaching costs in hospitals. "Ultimately, the state is going to say, 'Our programs are to give care to the indigent, and not to support medical education. The universities are supposed to do that.' "

Physicians in training, Gonzales complained, order many more tests than are necessary. "The new guys order one of each. It's like they're in a candy store. When a new class begins in July, my service load goes way up."

Other administrators, however, are quick to point out a public hos-

Please turn to page 29

Residency programs may be cut in public hospitals

Continued from page 3

pital's dependency on residents. Elliott Robertson, director of Cook County Hospital, Chicago, explained that his 450 residents provide most of the hospital's direct patient care, under the supervision of a full-time, salaried faculty. "It would cost more if we were to go out and hire (fully trained) physicians to replace residents," he said.

Roberts added that his faculty physicians are willing to take lower salaries because they enjoy teaching. If they were hired solely to provide patient care, they "would want the going rate — which may be twice as much," he said.

Glenn Potter, vice president of operations for the Cuyahoga County Hospital System in Cleveland, agreed that dismantling his residency program would be "cutting off our nose to spite our face."

"We might cut back on the dental residency program, and we might squeeze more money out of the medical school, but we're dependent on our 300 residents to provide care," he said. Although patient care is a first priority, teaching "runs a close second," he added.

American Medical
NEWS

Nation's public hospitals set to battle in Washington

Top administrators from the nation's largest public hospitals, complaining bitterly about cuts in federally financed programs such as Medicaid, have agreed to redouble their lobbying efforts in Washington.

Meeting in Denver for the first conference of the National Assn. of Public Hospitals (NAPH), the administrators also discussed strategies for caring for the same number of poor patients with less federal money.

Founded just a week before President Reagan took office, the NAPH now has 27 members out of the 90 hospitals nationwide that fit its criteria of being large, urban, and public, said Larry Gage, NAPH general counsel.

Speaking to the administrators were several luminaries from the Carter Administration, including Joseph Califano, former Secretary of Health and Human Services. Conspicuously absent from the podium were any representatives from the Reagan Administration.

Califano exhorted public hospital administrators to advance their point of view in Congress. "Never in my 30 months (as HHS Secretary) did I hear from anyone from public hospitals," he admonished his audience. "You must redouble your efforts to make sure legislators know what you do."

Elliott Roberts, director of Cook County Hospital in Chicago and newly elected chairman of NAPH's board, conceded that "we're painfully aware of our lack of voice over the years."

Photos: Doug Lefton/AMN

Elliott Roberts (left), director of Chicago's Cook County Hospital, is: "Painfully aware of our lack of voice over the years." Former HHS Secretary Joseph Califano's message: "You must redouble your efforts to make sure legislators know what you do."

THE ADMINISTRATORS were particularly worried about cuts in Medicaid and Medicare that the Reagan Administration is expected to propose to Congress. Last year's cuts in Medicaid and the block grant programs have had disastrous effects on the "hospitals of last resort" — the public hospitals, they said.

The administrators described a sort of chain reaction that occurs when federal funds to a state-run program such as Medicaid are reduced. The state tends to respond by tightening eligibility requirements, which drops people from Medicaid roles, and by lowering reimbursement rates. Voluntary hospitals then find it uneconomical to care for a growing number of poor people and "dump" them on the nearest public hospital. The public hospital, which must accept all patients, is then left with a bill that no one will pay —except the city or county. Cities and counties, in turn, can absorb only so much of the shifted burden, administrators say.

"We can't exclude some patients the way private providers do. Nor would we want to," said J. L. Kurowski, MD, manager of health and hospitals for the city of Denver. "We're caught between two mandates — a mandate to serve the poor and a mandate to remain fiscally sound."

A dramatic example of patient-dumping occurred last year at Cook County Hospital, after Illinois Gov. James Thompson imposed a $285-per-day limit on public assistance for inpatient care. Patient transfers to the public hospital jumped from an average of 90 to 125 per month to a high of 560 in August, Roberts said. Patients came from "nearly every voluntary hospital in the area," he said.

Said Gordon Howe, associate administrator of the Denver General Hospital: "The (local) tax base doesn't increase fast enough to support the increasing cost of health care. Unless we get more funding, the situation is going to get worse, not better — and a lot of people that deserve health care aren't going to get it."

THE DENVER SYSTEM of a central public hospital and eight satellite health centers laid off 300 people and reduced its budget by $10 million last year, Howe said. Included were cuts in mental health, dental care, and substance abuse — programs Denver health officials considered preventive medicine. The cuts were necessary because the state would not increase its assistance for the medically indigent in Denver, and Denver had no more money for health care.

"The bottom line is very simple," Howe "If you incur costs, somebody has to pick up the tab. If nobody is there to pick up the tab, something has to go."

As public hospitals stick their local governments with higher and higher deficits, the local governments will put increasing pressure on the public hospitals to avoid unnecessary care, predicted William Gonzales, director of the U. of California's Medical Center at Irvine.

Orange County is already refusing to pay a large number of claims submitted by the medical center, he said. The county, which apparently is scrutinizing claims like a hard-nosed utilization review panel, contends that the rejected claims were for care that was excessive, duplicative, too expensive, not clinically justified, or available elsewhere at lower cost, Gonzales said.

The medical center's remedy for disallowed claims is an arbitration board. The center now has $11 million worth of claims in arbitration, Gonzales said.

The county is even challenging trivial bills and pursuing them through arbitration, Gonzales said. He related one case about a woman who was at a cocktail party, spilled her drink, and stepped on a toothpick that fell from the glass. The toothpick "perforated" her foot, but didn't go all the way through, and her friends took her to the medical center's emergency room. The county didn't want to pay the woman's bill: It claimed the case was not an emergency and that she didn't really need the crutches that were issued to her.

"Thousands of dollars in lawyer's fees were spent arbitrating whether that was a justifiable expense for the county of Orange to pay," Gonzales said.

After sitting through numerous arbitration proceedings, he has come to believe that many tests are unnecessary and that many patients are kept in the hospital too long, Gonzales said. He suggested that housestaffs should be reduced in number and more carefully supervised, a view that brought at least one enthusiastic response from the attendees.

IN DISCUSSING the upcoming Administration proposals, the administrators agreed that the various "competition" proposals being discussed in Washington could only have a deleterious effect on public hospitals, whose patients have no money to compete with and who would be poor insurance risks compared with wealthier and healthier people. Medicaid caps were even more vehemently opposed: One speaker said that "a cap would not deal with the causes of health care inflation — it would just shift costs to the states" — and, implicitly, to beleagured local governments.

The public hospital administrators had few solutions to health care inflation, and the several that were advanced were in the embryonic state. Arnold Leff, MD, director of the Contra Costa County (California) Health Services Agency, talked about the public hospital in Contra Costa, which was the nucleus for the first publicly sponsored health maintenance organization in the country. "We're less costly than fee-for-service in our county," he said.

David Rosenbloom, PhD, Boston's commissioner of health and hospitals, suggested that perhaps public hospitals could be merged into the voluntary hospitals, with the voluntary hospitals absorbing a share of the bad debt that non-paying indigent patients bring. "For volunteer hospitals, it may be better than having the public hospital close," he said.

Dr. Rosenbloom also suggested that public hospitals could cut down on teaching expenses and residents, and still maintain good and perhaps even better patient care.

As a third strategy Dr. Rosenbloom urged his colleagues to explore the Economic Tax and Recovery Act of 1981 for any tax advantages that might be usable by a public hospital. The mayor of Boston has announced that "the reorganization and refinancing of the hospital" is being considered; among the possibilities being studied is selling the hospital to a private entity with a lease-back agreement, Dr. Rosenbloom said.

—Doug Lefton

1980 Public Hospital Revenues, By Source

	Parkland Memorial Hospital, Dallas	Grady Memorial Hospital, Atlanta	Truman Medical Center, Kansas City	Cook County Hospital, Chicago	Boston City Hospital	Nassau County Medical Center, New York
Medicaid	7%	20%	18%	33%	26%	23%
Medicare	17%	19%	19%	8%	18%	19%
City/county payments	54%	40%	37%	50%	23%	21%
State payments	0	3%	3%	0	0	2%
Private insurance—self pay	18%	8%	12%	7%	25%	26%
Other	4%	10%	11%	2%	8%	9%

Source: National Assn. of Public Hospitals

WASHINGTON REPORT ON
Medicine & Health PERSPECTIVES
JEROME F. BRAZDA, Editorial Director
A McGRAW-HILL PUBLICATION
September 14, 1981

THE PUBLIC HOSPITAL: PROVIDER OF LAST RESORT

After prompting from Congressional health leaders, the Carter Administration last year launched a program to give grants to financially distressed public and inner city hospitals. Months later, only three hospitals have received these demonstration grants. In the meantime, the fiscal position of the public hospitals has eroded greatly.

The most immediate problem for public hospitals is Medicaid cuts. This year, more than half the states had Medicaid deficits. The federal Medicaid cuts passed in the recent Omnibus Budget Reconciliation Act will worsen the situation. In preparation, many states are considering or have already passed legislation to trim back their Medicaid programs. When the appropriations process is over, and the Medicaid financial picture is clearer, many more states will follow suit. And, according to Mark Steinberg of the American Hospital Association's Public General Hospital Division, these cuts will affect public hospitals most seriously.

Recent events in Los Angeles County provide a dramatic illustration of the impact of such cuts, especially when coupled with an eroding state or local tax base. In making health care cuts of $100 million, the Los Angeles County Board of Supervisors overnight shut down eight clinics and one inpatient hospital. The hospital was told to ship off its patients, including those who'd just had surgery, to other facilities. The California Department of Health Services filed suit, and although the board is now prohibited from making further cuts without adequate notice, it was not required to restore the services.

Of the various types of Medicaid cuts, the tightening of beneficiary eligibility requirements hurts public hospitals the most. This leaves many more people without any form of insurance and with nowhere to turn for medical care except to the public hospital -- which will not receive Medicaid reimbursement for their care. States do not have to make specific cuts, although many are considering them in the form of elimination of "medically needy" programs and elimination of coverage for 18 to 21 year olds, to reduce the number of eligible persons. Failure to raise maximum income levels to keep pace with inflation has the same effect. In the past few years, there has been a 35 percent decline in the number of patients at Cook County Hospital in Chicago, Ill., receiving Medicaid reimbursement and an upsurge in the incidence of "patient dumping" or inappropriate transfer of uninsured patients from other hospitals. At Cook County, such transfers rose from 70-90 per month early in the year to 363 in July. The likely weakening of Hill-Burton regulations (see Perspectives, August 24) will accelerate this trend. This decrease in Medicaid reimbursement and corresponding in-

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crease in the number of non-paying patients can break the back of the public hospital. Public hospitals in New York and Philadelphia, for instance, once received two-thirds of their patient revenues from Medicaid, and other public hospitals average 35 percent to 80 percent.

Other cuts contemplated by the states also would hurt public hospitals. Limiting the number of reimbursable hospital days would penalize public hospitals because they tend to have an expensive case mix -- that is, poor people who are sicker and require longer hospital stays. The limitation would also discourage other hospitals from accepting seriously ill Medicaid patients and result in more patient dumping. Refusal to reimburse public hospitals at acute care rates for providing long-term care when no appropriate nursing home services are available also penalizes the public hospital; Washington's D.C. General loses $10 million annually because it can't place such patients. Limitations on types of services covered and on the number of outpatient visits are measures other states are considering. An AHA spokesman predicted that outpatient services, such as mental health and alcoholism programs not provided by other facilities, would be among the first to be cut. Some states are also considering limiting the number of laboratory tests and x-rays for which they will reimburse. This presents a special problem for public hospitals affiliated with medical schools because such institutions often use more tests than private sector hospitals because of their educational mission. This would add to the burden the public hospital already faces in providing such tests for non-paying patients.

Hospitals that take a large number of Medicaid patients suffer from present Medicaid reimbursement methods as well. Medicaid often pays less than it costs to treat a patient and, unlike Blue Cross, doesn't reimburse hospitals for a portion of their bad debts. In addition, while public hospitals provide twice as much outpatient care as those in the private sector, Medicaid reimbursement tends to favor those that provide inpatient care.

PUBLIC HOSPITALS AND THE COMPETITION MODEL

Shrinking tax bases and federal Medicaid cuts are not the only threats to the survival of public hospitals. Many health care advocates, such as Dan Sigelman of the Health Research Group, feel that pro-competition models backed by the Reagan Administration would prove life-threatening to public hospitals as well.

The competition bill (S.433) introduced by Sen. David Durenberger (R-Minn.), Sigelman says, doesn't address the needs of poor people. H.R. 850, introduced by Rep. Richard Gephardt (R-Minn.) would provide for the uninsured poor and after four years would allow state Medicaid programs to buy into the system as well.

But low-income people are generally less healthy and consequently more expensive to treat than wealthier people, Sigelman points out. They have higher hospital admission rates, more disability days, and longer average lengths of stay. Therefore, a community-rated, capitation-financed health plan would have few incentives to enroll them. This was illustrated in the case of Oregon's Project Health (see Perspectives, August 17) which was forced to double the dollar amount of premiums for the high option plans that attracted the less healthy individuals. Aware of this, Walter McClure, a highly regarded competition expert, suggests that the poor not be included in competition plans in the beginning, while Alain Enthoven, a leading proponent of competition, recommends that the purchasing power of vouchers for the poor be high enough to ensure acceptance into a plan. Anything short of increased payments will not encourage plans to enroll them. (The Gephardt bill, however, does not consider income level as a factor in setting plan rates. Therefore the plans would be motivated to "skim" by enrolling only the more healthy, higher income patients.)

Further, Sigelman states, competitive plans would be unlikely to contract with providers, such as public hospitals, that were located in or near low-income, high health risk neighborhoods. And if a plan did locate in such an area, high-income patients from other areas would be unlikely to enroll, further exacerbating the problems of adverse risk selection.

Therefore the public hospital could be left out of the competitive market but remain as the provider of last resort for the poor, if it survived its operating losses. Public hospitals lack access to the capital loan market and equity sources such as philanthropy or stock. Further the federal loan guarantees on which many public hospitals rely are presently in a precarious position. These factors would further erode the competitive position of the public hospital. Additionally, the Gephardt bill would eliminate Hill-Burton requirements, dumping the uninsured, non-paying patients once again in the lap of public facilities.

PUBLIC HOSPITALS AND CONTRACT MANAGEMENT

Of course, there are those who charge that public hospitals suffer large operating deficits and can't compete with other hospitals -- not because they treat the uninsured -- but because they are inefficiently managed. In some cases, this may be true. Studies have shown that in other cases, it is not. The California Health Facilities Commission found that, considering their case-mix, public hospitals, whose costs per discharge were once 106 percent of the average, had cut their costs by 1978 to 91 percent. A Blue Cross study of hospitals in Chicago found that Cook County Hospital had the lowest cost per case, lowest average stay, and was most efficient over-all. Nevertheless Cook County Hospital, like many other public hospitals with operating deficits across the country, has recently contracted with a proprietary management chain.

Many health care advocates consider contract management as great a threat to the mission of public hospitals as Medicaid cuts and competition bills. They charge that when contract management saves money, it is not, as the chains say, through bulk purchasing, shared services, and more efficient bill collecting, but through denying access to care, lowering staffing ratios, and raising charges. One reality is that contract management is a growing trend and often does end financial deficits. Most of the public hospitals presently under contract management are small (under 100 beds), rural, and located in the south. A study by Lewin & Associates, a Washington, D.C., consulting firm, of financially distressed hospitals changing to contract management, found that almost all of them had surpluses within two years. Yet, in many cases, advocates can point out how this was accomplished. Hyatt Medical Management receives $10,000 a day for consulting with Cook County Hospital. Since this began, the per diem rate has gone up to $630 a day -- and to $1,500 a day for intensive care. As for access, the administrator of a Hyatt-managed public hospital in Calexico, Calif., has stated, "We treat true emergencies, but for other cases and elective admissions, we require proof of ability to pay." A study of contract managed hospitals by Accountants in the Public Interest (API) concluded that "improved financial stability was a result of price increases."

City officials surveyed by the National League of Cities seemed, like API, to be leery of the contract management firms. They advocated improved bill collections, attracting paying patients, and resource sharing among hospitals. They rejected converting the facilities to private ownership or management or reducing services. Nevertheless, they felt that the hospitals should be self-sufficient and should not depend on the city to raise taxes or increase bonded indebtedness in order to finance them.

Vito Rallo, Administrator of Cincinnati General Hospital agrees with them. Many private hospitals are diversifying by involving themselves in ventures not totally related to medicine. He feels that public hospitals can do so as well, although with more political difficulty. Cincinnati General itself is hoping to open a Nautilus fitness center that would complement its sports medicine department. This would not be, he stresses, to supplant the public hospital's mission, but to help support it.

Other people look for alternative ways to help public hospitals survive. Contra Costa County, California, turned its hospital into a health maintenance organization. Although there were initially charges of marketing misrepresentation, the plan is now moving into its final phase and enrolling paying patients. Rate-setting formulas in New Jersey and Maryland help public hospitals because the payment is by diagnosis, which allows for the hospitals' adverse case-mix, and because the formula includes allowances for bad debts. Others advocate requiring Medicaid patients to use only public hospitals -- an idea that would secure financing for the hospitals but that others charge would create a two-class system of medicine. And in Detroit, the public hospital has joined in partnerships with non-public facilities.

Meanwhile the American Hospital Association has recently conducted a survey that shows public hospitals, primarily rural public hospitals, are less likely to close than voluntary or for-profit hospitals. Urban public hospitals are more at risk; recent victims include New York's Greenpoint and Brooklyn Cumberland. More than 30 public hospitals have closed in California since 1966. Tackling the problem, the National Health Law Program soon will publish a manual, "The Struggles to Save Public Hospitals: An Advocacy Guide." It gives examples of innovative mechanisms to support them, but it ends on a sad note. The four successful public hospitals it chose to examine -- including one that had formed a consortium with a Public Health Service hospital -- are all now experiencing difficulty in staying afloat.

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Public hospitals

Winning finance control offers needed protection

Gaining control of financial resources is the only way public hospitals will be able to cushion the impact of unfavorable external political and economic forces, says Elliott C. Roberts Sr., director of Chicago's Cook County Hospital.

The negative impact of external forces was illustrated in July when nonprofit private hospitals increased their transfers to Cook County in record numbers following cuts in state welfare medical payments, said the director of the 1,455-bed hospital (see adjacent story).

Federal and state policies can upset public hospitals' precarious finances

It was another example of how policy changes at the federal or state level can upset the precarious finances of Cook County and other public hospitals, Mr. Roberts said. The local government "needs some control of the expenditure of funds."

Under the healthcare system Mr. Roberts visualizes, the local government could provide care through its public hospital system or through agreements with selected hospitals, physicians or clinics. Emergency care would be provided at any hospital, although the county would set limits on reimbursement.

"For instance, if we decided that Cook County would operate with 1,000 beds at 80% utilization, anything in excess of that would be farmed out to the appropriate setting," he said, adding that critics might say such a system takes away the patients' freedom of choice or that "local government is trying to create a socialized medicine structure."

Planning healthcare for unsponsored patients should involve a "clear agreement between the state and the local entity to allocate dollars to cover the citizens of a defined geographic area. Let the local governmental entity carry the responsibility for assuring that patients in the area receive the appropriate level of care in the appropriate setting," he said.

"Decisions made precipitously at the federal and state level without input from the county board, or without time for the county to react, obviously could be a major factor in creating a negative climate," he said.

Cook County Director Elliott C. Roberts has spent more than a decade in public hospitals

Mr. Roberts, 54, has spent more than a decade of his 28-year career in public hospital administration. He first came to Cook County Hospital as part of the Hyatt Medical Management Services team contracted by the county Board of Commissioners in May 1980 to improve management. The board hired Mr. Roberts away from Hyatt in December 1980 to serve as hospital director. He also has been administrator of Mercy Douglass Hospital in New York City, Detroit General Hospital and Charity Hospi-

Continued from page 55

tal in New Orleans.

Mr. Roberts repeatedly has dealt with the same difficulties that Cook County faces—too many patients, too little staff and limited financial resources.

The underlying problem is that society has yet to address realistically the problem of providing healthcare for the poor, Mr. Roberts said. Although in the ideal world there would be only one system of medical care, "the bottom line is we have always had a two-class system, and we will always have a two-class system," he said.

"The sooner we recognize that, the sooner we can decide how to perform in that setting."

Equal access to quality healthcare has "never existed" for the poor, Mr. Roberts noted. "We recognize that and must make sure that healthcare of high quality is available to these people," he said. "We can't guarantee (patients' freedom to choose the hospital where they'll be treated), but we can guarantee that quality care is provided even without the nice setting of the private sector."

Although public hospitals often lack the "niceties" of voluntary hospitals, "one can expect to find 'tender, loving care' and an appreciation of the patient as an individual," he added. At Cook County Hospital, Mr. Roberts has attempted to maintain fiscal soundness while also providing comprehensive medical services to the community.

Responsibility for providing healthcare for the poor in the community lies with local government, which has the taxing authority to provide such services, he said. Private, voluntary hospitals have "no place to turn when they render care to unsponsored patients. The voluntary hospital sector cannot absorb the losses and should not be expected to absorb the losses."

How much of a financial burden local government is willing to assume isn't clear, however. "Obviously, someone will have to look at what the upper limits might be in terms of reasonableness as it relates to cost. I don't feel we are at a danger point in Cook County since the tax base until now has been sufficient without increasing the bill to county taxpayers," he said.

Throughout his career with public hospitals, funding has always been a problem "because very few governmental entities have an unlimited pocketbook," he said.

"That's the politics of operating a public hospital. Public hospitals have a history of being underfunded. Very few could stand up to the voluntary hospital in terms of salaries, the physical plant and the niceties."

Although voluntary hospitals have accepted marketing as "ethical and appropriate" for economic survival, public hospitals "aren't in the business of marketing their services to patients," the Cook County Hospital director said.

If a public hospital, like Cook County, doesn't market its services, it can only react to external forces

"The patients come to the hospital because they are brought or someone sends them," Mr. Roberts noted. "The public hospitals don't reach out and pull them in."

Public hospitals are precluded from "actively marketing for patients" because their tax-supported status "could place voluntary hospitals at a disadvantage," Mr. Roberts said. But the public hospital sector could seek out the patients who will be overlooked by voluntary hospitals that target their marketing efforts toward paying patients.

"If public hospitals fail to do some marketing, they will remain in the position of only being able to react to the market. No viable business organization can afford to experience any degree of success without a plan, a direction or an objective. Public hospitals have an even greater obligation because they are taxpayer-supported institutions," he said.

Although faced in early 1980 with a $90 million budget deficit incurred by the now-defunct Cook County Health and Hospitals Governing Commission, Mr. Roberts and the Hyatt team have cleared up many of that hospital's financial difficulties.

For the past two years, the hospital has stayed within budget without any "disruptions in service, reductions in service or layoffs. In fact, we had sufficient revenues to increase salaries as well as look at some appropriate increases in programs," Mr. Roberts said.

Aiding in the hospital's financial recovery was the county board's decision to double the institution's share of property tax revenues. The county board also approved a $.05 per pack cigarette tax, generating additional revenue for the hospital.

At the same time, Hyatt tightened collection procedures and established a unit to assist patients in obtaining Medicaid eligibility. The result was an additional $30 million in revenue in 1980 and 1981 combined. During the past year, the hospital generated $83 million of its total $170 million budget.

The hospital still faces major problems, including staff shortages and aging facilities. It recently hired a recruiter to assist in filling positions, Mr. Roberts said. "We've experienced some positive results. We've had less turnover, and we're beginning to see hirings exceed terminations," he said, adding that the hospital has used a registry to fill its nursing needs temporarily.

The hospital facilities also need improvement to comply with local building codes and standards set by the Joint Commission on Accreditation of Hospitals.

"One of the charges given Hyatt is to develop a long-range facilities and programs master plan. Among the alternatives would be construction of a new hospital or renovation of the existing building. The county board must decide what will happen," Mr. Roberts said.

During his tenure at Cook County Hospital, the board has never rejected "any justified request," Mr. Roberts said, adding that the "big one is yet to come—whether I get a new hospital."

Despite the often overwhelming problems facing the hospital, Mr. Roberts said that he finds the job "exciting, unique and rewarding.

"It takes a little bit of hard work and dedication and an awful lot of patience," he said. "There are no miracles." —*L.P.* ■

Public hospitals straining to survive federal assault on healthcare costs

By Linda Punch

The federal government's assault against rising Medicare and Medicaid expenditures already is taking a heavy toll on many of the nation's big-city public hospitals.

"The principal villain" is tighter Medicaid eligibility criteria: Boston commissioner David Rosenbloom

As some industry observers see it, the nation's public hospitals are facing an impending national crisis because of government cutbacks in support for health services for the poor. In Atlanta, Grady Memorial Hospital expects its 1982 budget deficit to double as a result of Medicaid cuts. In Los Angeles, the county hospital system already is cutting $75 million from its budget and predicts that larger cuts are in the offing.

The financial problems appear so overwhelming that at least one public hospital administrator sees public hospitals closing rather than face the impossible task of providing healthcare to the poor without adequate funding. And ultimately, he predicts, the burden of caring for the poor will fall on the private sector, which so far has escaped the financial distress descending on its public sector counterparts.

Although government decisionmakers' concerns about "health cost inflation and economic stability are legitimate ones, there has been inadequate attention to the drastic cumulative impact of their decisions," said Larry S. Gage, general counsel for the National Assn. of Public Hospitals. "Our nation's public hospitals—who deliver the bulk of these services—must translate the abstract political decisions into the harsh reality of medical attention denied."

Cook County Hospital in Chicago was one of the first hospitals hit by budget cuts. Patient transfers from voluntary hospitals "suddenly increased" there after Illinois Gov. James R. Thompson imposed a $285-per-day ceiling on public assistance for inpatient care.

"In July, when the ceiling first took effect, patient transfers increased to 360. It rose to 560 transfers in August and back down to about 350 in September. This compared with anywhere from 90 to 125 transfers a month throughout the previous year," said Elliott C. Roberts Sr., hospital director.

The problem was alleviated temporarily when Gov. Thompson "did a reversal" and added $88 million to the budget for healthcare, Mr. Roberts said. The governor also agreed to reimburse hospitals on a reasonable cost basis rather than the previously established ceilings. The new guidelines came just before implementation of an Oct. 1 ceiling of $400 per day on Medicaid payments.

The hospital is now in "a situation similar to last year," Mr. Roberts said. "We will be paid for the services we provide." However, if the additional state funds for healthcare are depleted before the end of the fiscal year, he noted, "I perceive the same problems as in July but with different ground rules. This time there won't be any money available."

Illinois isn't the only state where budgets are being pinched. The impact of California's Proposition 13 is just now hitting public hospitals, said Robert W. White, director of health and hospitals for Los Angeles County.

Public hospitals may close, faced with the impossible task of caring for the poor

"We're in the process of cutting about $75 million in programs from the system, including elimination of ambulatory care from 42 health centers, elimination of eight health centers and a 10% (budget) cut in all the hospitals," Mr. White said.

County officials expect the financial situation to deteriorate further in the aftermath of federal cuts in Medicaid funds and block grants.

"Our estimate is that Los Angeles County will lose $13 million in Medicaid, resulting in about a $25 million cut in programs," he said, adding that the state Medicaid program already has a deficit of from $180 million to $200 million.

"The state has the authority to cut payments back by 10% but nothing has happened yet. We may have further program reductions in January based on the effect of Medicaid, federal cuts and block grants. I don't see any relief in the near future," he said.

A $67 million cut in Georgia's Medicaid program will result in an estimated $4 million loss in revenue for Grady Memorial Hospital in Atlanta, said J.W. Pinkston, hospital director. The hospital already faces a $4 million deficit in its $95 million budget in 1982 because of inflation.

"We were getting along all right, but next year we expected problems because of inflation," he said. "The Medicaid cuts have made it twice as bad. We either have to find a way to bring additional money to Grady or cut a major chunk out of the hospital," Mr. Pinkston said.

The hospital also expects an in-

Continued from page 55

Double trouble in L.A. for Robert W. White: Proposition 13 and federal cuts

crease in patient transfers because of the cuts but, "we'll have less money" to treat patients, Mr. Pinkston added. The 930-bed hospital handles about 750,000 clinic visits annually.

"If something is not done soon, we're going to be in very, very serious financial condition. The county already is supporting us by supplying 43% of the budget. That's all they can do," he said.

In Massachusetts, state officials announced that Medicaid reimbursement for chronic disease hospitals will be reduced to skilled nursing home rates for patients who should be in nursing homes. The cuts, effective Jan. 1, will be made "whether or not there are beds available" in long-term care facilities, said David Rosenbloom, Ph.D., commissioner of health and hospitals for the city of Boston.

"That could mean a reduction of as much as $100 per day per patient and would cost the city about $5 million per year," he said, adding that "it's too early to tell how other budget cuts will affect us."

"The principal villain isn't the nickle and diming on reimbursement rates. It's the number of people who will lose their Medicaid eligibility and end up at this hospital," Dr. Rosenbloom said.

Many voluntary hospitals already are turning away Medicaid patients seeking elective procedures, fearing that many of them will lose Medicaid eligibility under the cuts, he said.

"The immediate impact of these cuts is to engender substantial fear among the poor that they will lose their healthcare benefits," Dr. Rosenbloom said, terming the cutbacks "an outrage" that will place a heavy burden on public hospitals.

Private sector hospitals think they can protect them selves by freezing out Medicaid patients, but they can't

"The industry will be relatively unscathed because everybody but the public hospitals can escape. The only hospitals that can't escape will be those taking care of large numbers of poor and elderly—the inner-city hospitals," he said.

The poor are not responsible for the spiraling inflation in the healthcare industry, Dr. Rosenbloom added. "The hospital industry as a whole is guilty of price gouging and inflation. The legislation setting up Medicaid and Medicare guaranteed the inflation that followed," he said.

J.L. Kurowski, M.D., already has seen "patient dumping" at Denver General

Another factor in the high cost of healthcare for Medicaid patients is that in "big cities, teaching hospitals are the primary source of care for the poor," Dr. Rosenbloom said.

"A teaching hospital is an extremely expensive way of providing care. There was enormous inflation because the cost of medical education was tacked onto Medicaid bills," he said.

Dr. Rosenbloom warned that Medicaid cuts eventually will hurt the private sector hospitals. "They think they can protect themselves by freezing out Medicaid patients, but they're going to find that public hospitals will close rather than have that happen. And then they (voluntary hospitals) will have the ball," he said.

Budget cuts in Colorado will place "greater pressure on public funding sources, which already are strained," said J.L. Kurowski, M.D., manager of health and hospitals for the city of Denver. Although there have been no reductions in Medicaid reimbursement rates, there have been cuts in the number of people eligible for basic categorical assistance programs such as Aid to Families with Dependent Children, he said.

"We're not sure of the number of people involved since it's just being implemented," Dr. Kurowski said, noting that the AFDC rolls alone will be cut by 1,500 people.

"At the same time people are removed from AFDC, they're removed from the Medicaid rolls," he said. "That means we'll have the same patients with no money or new patients (from voluntary hospitals) with no money. We don't know which it's going to be."

Denver General Hospital already is experiencing "patient dumping" in mental health, Dr. Kurowski said. "Community health centers aren't handling the problem of the chronically mentally ill patient with acute episodes. It's the most significant problem we have right now," Dr. Kurowski stressed.

A congressional hearing on the impact of fiscal 1982 budget reductions and program changes on healthcare for the poor will be conducted Jan. 12 in Denver by the House Ways and Means Committee's subcommittee on oversight and investigations. Rep. Charles Rangel, D-NY, is subcommittee chairman.

After the hearings, the National Assn. of Public Hospitals will conduct its first annual conference Jan. 13-14 at the Stapleton Plaza Hotel in Denver.

The conference will examine the impact of current health budget and program reductions on the ability of public hospitals to serve their communities. Conference speakers will include former Dept. of Health, Education and Welfare Secretary Joseph A. Califano Jr. and Rep. Rangel. ■